PRIVATE DUTY NURSING & HOME HEALTH SERVICES
TABLE OF CONTENTS

PRIVATE DUTY NURSING & HOME HEALTH SERVICES
TABLE OF CONTENTS
(continued)

PRIVATE DUTY NURSING & HOME HEALTH SERVICES
TABLE OF CONTENTS
(continued)

PRIVATE DUTY NURSING & HOME HEALTH SERVICES
TABLE OF CONTENTS
(continued)

PART L - DIVISION II
PRIVATE DUTY AND HOME HEALTH SERVICES PROVIDER HANDBOOK
TRANSMITTAL LOG

This log is designed as a convenient record sheet for recording receipt of handbook updates. Providers must delete old pages and insert new pages as instructed. Use of this log helps eliminate errors and ensures an up-to-date handbook.

Each update to Part L – Division II of the handbook is numbered sequentially. This sequential numbering system alerts the providers to any updates not received. For example, if the last transmittal number on your log is 2L-3 and you receive 2L-5, you are missing 2L-4. If a provider is missing a transmittal, copies of complete provider handbooks may be purchased by completing the order form in Appendix 36 of Part A of the WMAP provider handbook.

Transmittal Number	Initials	Issue Date
2L-1		12/92
2L-2		01/94

Transmittal Number	Initials	Issue Date

INTRODUCTION

The Wisconsin Medical Assistance Program (WMAP) is governed by a set of regulations known as the Wisconsin Administrative Code, Rules of Health and Social Services, Chapters HSS 101-108, and by state and federal law. These regulations are interpreted for provider use in two parts of the WMAP provider handbook. The two parts of the handbook are designed to be used in conjunction with each other and with the Wisconsin Administrative Code.

Part A of the WMAP handbook includes general policy guidelines, regulations, and billing information applicable to all types of providers certified in the WMAP. The service specific part of the handbook includes information on provider eligibility criteria, covered services, reimbursement methodology, and billing instructions. Each provider is sent a copy of the Part A and appropriate service specific part of the handbook at the time of certification.

Additional copies of provider handbooks may be purchased by writing to the address listed in Appendix 3 of Part A of the WMAP Provider Handbook.

When requesting a handbook, be sure to indicate the type(s) of service provided (e.g., physician, chiropractic, dental).

It is important that both the provider of service and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of WMAP policy and billing procedures.

NOTE: For a complete source of WMAP regulations and policies, the provider is referred to the Wisconsin Administrative Code, Chapters HSS 101-108. In the event of any conflict in meaning between HSS 101-108 and the handbook, the meaning of the Wisconsin Administrative Code will hold. Providers may purchase HSS 101-108 from Document Sales at the address listed in Appendix 3 of Part A of the WMAP Provider Handbook.

Providers should also be aware of other documents, including state and federal laws and regulations, relating to the WMAP:

- Chapter 49.43 - 49.497, Wisconsin Statutes.
- Title XIX of the Social Security Act and its enabling regulations, Title 42 - Public Health, Parts 430-456.

A list of common terms and their abbreviations appears in Appendix 30 of Part A of the WMAP Provider Handbook and also in the Wisconsin Administrative Code, Chapter HSS 101.

A. TYPE OF HANDBOOK

Part L, Division II, Private Duty Nursing and Home Health Services, is the service-specific portion of the Wisconsin Medical Assistance Provider Handbook. Part L includes information for providers regarding provider eligibility criteria, recipient eligibility criteria, covered services, reimbursement rates, and billing instructions. Part L is intended to be used in conjunction with Part A of the Wisconsin Medical Assistance Provider Handbook which includes general policy guidelines, regulations, and billing information applicable to all types of providers certified in the Wisconsin Medical Assistance Program (WMAP). The detailed Table of Contents is designed to help you readily locate information in this reference tool.

B. PROVIDER INFORMATION

Provider Eligibility and Certification as a Home Health Agency

A provider must be certified by the WMAP in order to be reimbursed by the WMAP for providing services. For WMAP certification, a home health agency must be certified to participate in Medicare as a home health agency, be licensed according to ch. HSS 133, Wis. Admin. Code, and meet the following requirements in Section HSS 105.16, Wis. Admin. Code.

1. On a visiting basis, in a place of residence used as a recipient's home, provide at least part-time, intermittent skilled nursing services, which are performed by a registered nurse (RN) or licensed practical nurse, and home health aide services. Other home health services (physical therapy, occupational therapy, speech and language pathology services, disposable medical supplies and durable medical equipment) may be provided.

2. All home health services must be provided in accordance with orders from the recipient's physician in a written plan of care, which may include a plan update or interim orders, that the physician reviews at least every 62 days or when the recipient's medical condition changes, whichever occurs first.

In addition, home health agency responsibilities, specified in HSS 105.16, Wis. Admin. Code, must be followed in order to maintain WMAP certification.

No separate certification is necessary for a WMAP-certified home health agency to provide private duty nursing, durable medical equipment (DME), disposable medical supplies (DMS), or enteral nutrition products and supplies. However, providers must notify EDS in writing if they provide DME or DMS in order to receive applicable policy and billing information. Written notification must be sent to the following address:

EDS
Attn: Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

Home health agencies must become separately certified in order to provide Respiratory Care Services (RCS) or personal care services. Requirements for RCS certification are in Part L, Division I of the WMAP Provider Handbook.

Home health agencies with multiple locations should refer to Section II-B of Part A of the WMAP Provider Handbook for additional certification information.

B. PROVIDER INFORMATION

Scope of Service

The policies in Part L govern services provided within the scope of the practice of the profession as

(continued)

defined in ss. 441.11(3), 441.11(4), 448.05, and 448.07, Wis. Stats. and HSS 107.11, 133, N6.03 and N6.04, Wis. Admin. Code. Covered services and related limitations are in Section II of this handbook. Home health agencies are reimbursed only for the specific services for which they are licensed.

Provider Responsibilities
Specific responsibilities as a provider under the WMAP are stated in Section IV of Part A of the WMAP Provider Handbook. This section should be referenced for detailed information regarding fair treatment of the recipient, maintenance of records, recipient requests for noncovered services, services rendered to a recipient during periods of retroactive eligibility, grounds for provider sanctions, and additional state and federal requirements.

Home health agency provider responsibilities, specified in HSS 105.16, Wis. Admin. Code, must be followed in order to maintain WMAP certification. Following is a list of responsibilities that must be followed for each service area.

Home Health Aide Services
Home health aides must be trained according to requirements issued by the Bureau of Quality Compliance (BQC).

Home health aides must be assigned to specific recipients by a registered nurse. Written instructions for recipient services must be prepared by a registered nurse, a physical or occupational therapist, or a speech and language pathologist, as appropriate.

Supervision, an ongoing process, must be provided in accordance with all licensing and federal regulations. At a minimum, the following must occur:

1. a registered nurse must make supervisory visits to the recipient's home as often as necessary, but at least every 60 days. Supervisory visits must include:
    a. a review and evaluation of the recipient's medical condition and medical needs according to the written plan of care during the period in which agency care is being provided;
    b. an evaluation of the appropriateness of the relationship between the direct care giver and the recipient;
    c. an assessment of the extent to which the goals are being met;
    d. a determination whether the current level of home health services provided to the recipient continues to be appropriate to treat the recipient's medical condition;
    e. a determination whether the services are medically necessary; and
    f. a discussion and review with the recipient about the services received by the recipient;
2. after each supervisory visit, the registered nurse must discuss the results of the supervisory visits with the LPN, home health aide, or personal care worker; and
3. results of each supervisory visit must be documented in the recipient's medical record.

B. PROVIDER INFORMATION (continued)

Therapy Services
Therapy services by home health agencies are provided by physical therapists, occupational therapists, and speech and language pathologists. The therapists and pathologists may be:

- employed by the home health agency;

- employed by an agency under contract to the home health agency; or
- independent providers under contract to the home health agency.

Private Duty Nursing Services

1. The following private duty nursing services can only be performed by registered nurses (RN):

   a. making the initial evaluation visit;

   b. initiating the physician's plan of care and necessary revisions;

   c. providing those services that require care of a registered nurse as defined in N6, Wis. Admin. Rule;

   d. initiating appropriate preventive and rehabilitative procedures;

   e. accepting only those delegated medical acts which RNs are competent to perform based on their nursing education, training, or experience; and

   f. regularly reevaluating the recipient's needs.

2. Nursing services not requiring a registered nurse may be provided by a licensed practical nurse under the supervision of a registered nurse. Licensed practical nurse duties include:

   a. performing nursing care delegated by an RN under N 6.03, Wis. Admin. Rule;

   b. assisting the recipient in learning appropriate self-care techniques; and

   c. meeting the nursing needs of the recipient according to the written plan of care.

3. Both RNs and LPNs must:

   a. arrange for or provide health care counseling within the scope of nursing practice to the recipient and recipient's family in meeting the needs related to the recipient's condition;

   b. provide coordination of care for the recipient, including ensuring that provision is made for all required hours of care for the recipient;

   c. accept only those delegated medical acts for which there are written or verbal orders and for which the nurse has appropriate training or experience;

   d. prepare written clinical notes that document the care provided within 24 hours of providing service and incorporate them into the recipient's clinical record within seven days; and

B. PROVIDER INFORMATION (continued)

"Clinical note" means a notation of a contact with a recipient that is written and dated by a member of a home health team providing covered services. The clinical note is usually completed during or after the visit or recipient contact. The clinical note describes signs and symptoms, treatment, drugs administered, the recipient's reaction, and any changes in the recipient's physical or emotional condition.

   e. promptly inform the physician and other personnel participating in the recipient's care of changes in the recipient's conditions and needs.

4. Nurses must maintain a medical record for each recipient. The record must document the nature and scope of all services provided and be systematically organized and readily accessible to authorized DHSS personnel. The medical record must include:

   a. the recipient's condition, problems, progress, and services rendered;

   b. recipient identification information;

   c. appropriate hospital information supplied by the hospital, including discharge information, diagnosis, current patient status, post-discharge plan of care;

   d. an admission evaluation and assessment of the recipient;

   e. all medical orders, including current written physician's plan of care and all interim physician's orders;

   f. a consolidated list of medications, including start and stop dates, dosage, route of administration and frequency. This list must be reviewed and updated for each nursing visit, if necessary;

   g. progress notes. Progress notes must be written as frequently as necessary to clearly and accurately document the recipient's status and services provided. "Progress note" means a written notation that summarizes facts about the care that was furnished and the recipient's response during a given period of time. A progress note may be part of a clinical note;

   h. clinical notes. Clinical notes must be written within 24 hours of providing service and incorporated into the recipient's clinical record within seven days; and

   i. written summaries of the recipient's care provided by the nurse to the physician at least every 62 days.

5. All private duty nursing providers must provide a written statement of recipient rights to the persons they are serving. The statement must be shared with the recipient, guardian, or any other interested party prior to providing services. The recipient or guardian must acknowledge the receipt of the rights in writing. Refer to Section I-D of this handbook for a list of recipient rights.

B. PROVIDER INFORMATION (continued)

6. All private duty nursing providers must follow universal blood and body-fluid precautions for each recipient for whom services are provided. All nurses must have the necessary orientation, education and training in the epidemiology, modes of transmission and prevention of HIV and other blood-borne or body fluid-borne infections. All nurses must use the protective measures that are recommended by the National Centers for Disease Control. This includes those measures that pertain to medical equipment and supplies intended to minimize the risk of infection from HIV and other blood-borne pathogens.

7. All private duty nursing providers must have the following back-up and emergency procedures in place.

a. Nurses or their employers must choose an alternate nurse to provide services to the recipient in the event they are temporarily unable to provide services. Recipients must be informed of the alternate nurse's name before the alternate nurse provides services.

b. Nurses or their employers must have a written plan for recipient-specific emergency procedures in case of a life-threatening situation, fire, or severe weather warnings. This plan must be given to the recipient and all caregivers prior to the initiation of these procedures.

c. Nurses or their employers must take appropriate action in the case of any significant accident, injury, or adverse change in the recipient's condition. Nurses must immediately notify the recipient's physician, guardian, if any, and any other responsible person designated in writing by the recipient or recipient's guardian.

8. All private duty nursing providers must discharge recipients from services according to the following guidelines:

a. Recipients must be discharged in the following situations:

- when the recipient requests to be discharged; or

- when the physician decides to discharge the recipient.

b. Recipients may be discharged when the nurse documents that continuing to provide services to the recipient presents a direct threat to the nurse's health or safety, and further documents that the physician has refused to discharge the recipient with full knowledge and understanding of the threat to the nurse.

c. Nurses must recommend discharge to the physician and recipient if the recipient does not require services or requires services beyond the nurses' abilities.

d. Nurses or their employers must give the recipient or the recipient's guardian a written notification of discharge. This must be done, if possible, at least two calendar weeks prior to the ending of skilled nursing services.

e. In all circumstances, nurses or their employers must provide assistance in arranging for the continuity of all medically necessary care prior to discharge.

B. PROVIDER INFORMATION (continued)

Reimbursement

Reimbursement for Home Health Services

Home health agencies providing home health services are reimbursed at the lesser of their usual and customary fee per home health visit or the maximum allowable fee per home health visit established by the Department of Health and Social Services (DHSS). Refer to Section II of this handbook for the WMAP's definition of a home health visit.

Reimbursement for Private Duty Nursing Services

Home health agencies providing private duty nursing services are reimbursed at the lesser of their usual and customary fee or the maximum allowable fee per private duty nursing hour established by DHSS.

C. QUALITY

Department of Health and Social Services (DHSS) Review

ASSURANCE

According to HSS 105.16(9), Wis. Admin. Code, the DHSS may periodically review provider records, subject only to restrictions of law. Providers must make all records immediately available upon the request of an authorized DHSS representative.

As part of a DHSS review, DHSS staff may contact recipients who have received or are receiving services from a provider. Providers must provide any identifying information requested by the DHSS. During this review, the DHSS may:

- select the recipients to visit; and
- visit a recipient (with the recipient's or guardian's approval).

The DHSS or other governmental investigatory agency will give the recipient the opportunity to have any person present whom he or she chooses during the visit by personnel of the DHSS or other governmental investigatory agency.

The DHSS may investigate any complaint that is received concerning the provision of services by a provider. Following the investigation, the DHSS may issue a preliminary final report to the provider in question, except in situations that would jeopardize any other investigation.

Termination of a Provider's Certification

The DHSS may terminate a provider's WMAP certification for failure to comply with the following requirements: HSS 105.19, 107.11, 107.113 or 107.12, Wis. Admin. Code, as applicable. In addition, the DHSS may terminate a provider's WMAP certification for any of the reasons described in HSS 106.06, Wis. Admin. Code.

Providers terminated for failure to comply with these requirements have 30 calendar days from the date of termination of certification to make alternative care arrangements for WMAP recipients under their care prior to termination. After the 30-day period, WMAP payment for services will stop, except for payments to providers terminated in situations where the recipient's health and safety is in immediate jeopardy. In these situations, as determined by the DHSS, the DHSS may make alternative care arrangements to provide continuity of care and protect the recipient.

The DHSS must provide at least 15 working days advance notice of termination to the provider, except in situations where the recipient's health and safety is in immediate jeopardy. In these situations, the DHSS provides at least five calendar days advance notice.

C. QUALITY ASSURANCE (continued)

Alternative Sanctions

The DHSS may take other actions (alternative sanctions) rather than termination of a provider's certification to ensure compliance with program requirements. If this is done, the DHSS may impose one or more of the sanctions for no more than six months following the last day of the DHSS review of the provider. At the end of the six-month period, if the provider continues to not comply with the WMAP requirement(s), the DHSS must terminate the provider's certification.

The DHSS may apply one or more of the following sanctions:

- suspension of payment for all new admissions;
- suspension of payments for new admissions who require particular types of services;
- suspension of payments for any WMAP recipient requiring a particular type of service;
- a plan of correction prescribed by the DHSS;

- provider monitoring by the DHSS;
- appointment of a temporary manager; or
- any of the sanctions that are described in HSS 106.07(4), Wis. Admin. Code.

In determining the most effective sanctions to be applied to a non-compliant provider, the DHSS takes into consideration the:

- severity and scope of noncompliance;
- relationship of several areas of the deficiencies or noncompliance;
- provider's previous compliance history, particularly as it relates to the insufficiencies under consideration;
- immediate or potential jeopardy to recipient care;
- direct relationship to recipient care; and
- provider's financial condition.

The DHSS may revisit the provider during the sanction period. Termination procedures may be initiated as a result of the review conducted during the revisit if substantial noncompliance is found to persist, or if recipient safety is potentially or actually compromised.

D. RECIPIENT INFORMATION

Eligibility For Medical Assistance

Recipients meeting eligibility criteria for Medical Assistance are issued Medical Assistance identification cards. The identification cards include the recipient's name, date of birth, ten-digit Medical Assistance identification number, medical status code, and, when applicable, an indicator of private health insurance coverage, managed care program coverage, and Medicare coverage.

D. RECIPIENT INFORMATION (continued)

Medical Assistance identification cards are sent to recipients on a monthly basis. All Medical Assistance identification cards are valid only through the end of the month for which they are issued. It is important that the provider or the designated agent check a recipient's Medical Assistance identification card prior to providing service to determine if the recipient is currently eligible and if there are any limitations to the recipient's coverage.

Section V of Part A of the WMAP Provider Handbook provides detailed information regarding eligibility for Medical Assistance, Medical Assistance identification cards, temporary cards, restricted cards, and how to verify eligibility. Section V of Part A must be reviewed carefully by the provider before services are rendered. A sample Medical Assistance identification card can be found in Appendix 7 of Part A of the WMAP Provider Handbook.

Managed Care Program Coverage

WMAP recipients enrolled in WMAP-contracted managed care programs receive a yellow Medical Assistance identification card. This card has a six-character code in the "Other Coverage" column designating the recipient's managed care program. These codes are defined in Appendices 20, 21, and 22 of Part A of the WMAP Provider Handbook.

Providers must always check the recipient's current Medical Assistance identification card for managed care program coverage before providing services. Claims submitted to EDS for services

covered by WMAP-contracted managed care programs are denied.

For recipients enrolled in a WMAP-contracted managed care program, all conditions of reimbursement and prior authorization for home health services are established by the contract between the managed care programs and certified providers.

Additional information regarding managed care program noncovered services, emergency services, and hospitalizations is included in Section IX of Part A of the WMAP Provider Handbook.

Copayment
Home health services and private duty nursing services, as well as DME and DMS provided by home health agencies, are not subject to recipient copayment.

Recipient Eligibility for Home Health Services
In order to qualify for covered WMAP benefits of home health services, a recipient must meet the confinement limitations as specified in Section II of this handbook and have a physician's prescription for medically necessary covered home health services. A recipient's residence cannot be a hospital or nursing facility.

Recipient Eligibility for Private Duty Nursing Services
In order to qualify for covered WMAP private duty nursing services, the recipient does not need to be confined to his or her residence. The recipient must have a physician's prescription for medically necessary private duty nursing services. A recipient's residence cannot be a hospital or nursing facility.

Recipient Rights for Recipients of Private Duty Nursing Services
According to HSS 105.16(10)(b), Wis. Admin. Code, all private duty nursing providers must furnish a written statement of recipient rights to the persons they are serving. The statement must be shared with the recipient, guardian, or any other interested party prior to providing services. The recipient or guardian must acknowledge the receipt of the rights in writing.

D. RECIPIENT INFORMATION (continued)

In addition to rights that all Medical Assistance recipients have, each recipient of private duty nursing services has the right to:

1. be fully informed of all rules and regulations affecting him or her;
2. be fully informed of the services that are to be provided by the nurse and of related charges, including any charges for services for which the recipient may be responsible;
3. be fully informed of one's own health condition, unless medically contraindicated;
4. participate in the planning of services, including referral to a health care institution or to another agency;
5 refuse treatment to the extent permitted by law and to be informed of the medical consequences of that refusal;
6. confidential treatment of personal and medical records and to approve or refuse their release to any individual, except in the case of transfer to a health care facility;
7. be taught, and have the family or other persons living with the recipient taught, the treatment that is required. The recipient has this right so that the recipient can, to the extent possible, help himself or herself, and the family or other party designated by the recipient can understand and help the recipient;

8. have his or her property treated with respect; and

9. complain about the care that was provided or not provided, and to seek resolution of the complaint without fear of recrimination.

A. INTRODUCTION

The Wisconsin Administrative Code, HSS 101-108, is a complete source of WMAP regulation and policies. In the event of any conflict in meaning between HSS 101-108 and this section, the meaning of the Wisconsin Administrative Code will hold. The intent of this section is to assist you in complying with administrative rule requirements.

Throughout this handbook, "home health services" describes home health nursing (part-time, intermittent nursing), home health aide services, therapy services, durable medical equipment (DME), and durable medical supplies (DMS). Private duty nursing services include nursing services of an extensive nature. The Wisconsin Medical Assistance Program (WMAP) reimburses certified home health agencies for two categories; home health services and private duty nursing services. These services are covered only when prescribed by a physician for an eligible recipient.

No provider may be reimbursed for services provided by a person who is not properly trained, as indicated by licensure, certification, or other documentation of training in the provider's personnel file. No WMAP policy or procedure may be construed to allow the provider to perform services in a manner which is not in compliance with a provider's license. All nurses should review the Nurse Practice Act (Chapter N6, Wis. Admin. Code) to ensure that they do not exceed their authority.

Other members of a recipient's household are encouraged to participate in providing care. However, this participation is not a condition of coverage. Members of the household must be asked by the provider about the extent they are able and willing to provide medically necessary covered services for the recipient, unless it is documented by the nurse that other members of the household are not capable and why they are not capable of providing care. The provider must document in the recipient's medical record if no member of the household is able and willing to provide care. A Community Options Program assessment or narrative reflecting possible informal support systems meets this requirement. Services furnished by the provider cannot be billed to the WMAP when family and other household members are able and willing to provide the medically necessary services.

Section II of this handbook defines the requirements for private duty nursing or home health service coverage by the WMAP. It defines key criteria such as the Plan of Care (POC) and Confinement Limitations. A subsection is devoted to each service area which defines the service and describes the limitations, including confinement and place of service limitations.

Finally, specific information is given which clarifies the definition of medical necessity for a particular level of service. This is not an exhaustive description of covered skilled nursing or therapy services. This information clarifies the criteria that the WMAP uses in determining medical necessity in reviewing prior authorization requests and in post-pay audits. The medical necessity criteria for skilled services are based upon the criteria used by Medicare, although the WMAP continues to cover medically necessary services, such as private duty nursing services and home health aides services without skilled intervention, which exceed Medicare's coverage limitations.

Clinical staff and directors of nursing should find the information in Section II of this handbook useful in determining whether services for a particular recipient are covered.

B. DEFINITION OF CONFINEMENT

A recipient is confined to the place of residence (HSS 101.03[31], Wis. Admin. Code) if a recipient's physical medical condition or functional limitation in one or more of the areas listed in HSS 134.13 (9) (c), Wis. Admin. Code (the areas include self-care, understanding and use of language, learning, mobility, self-direction and capacity for independent learning):

1. restricts the recipient's ability to leave his or her place of residence except with the aid of a supportive device such as crutches, a cane, a wheelchair or a walker, the assistance of another person or the use of special transportation;

2. is such that leaving the residence is medically contraindicated; or

3. requires a considerable and taxing effort to leave the home for medical services.

A recipient's place of residence is where the recipient makes his or her home, including the property on which the home is located. This may be the recipient's own dwelling, an apartment, or a relative's home. A hospital or nursing facility is not a residence for purposes of this section only.

The residence may also be a community-based residential facility (CBRF), except that home health services may not exceed the limits of chapter HSS 3, Wis. Admin. Code. Personal care services may not be provided in a CBRF with more than 20 beds. Services provided in a CBRF by a home health agency may not duplicate services which the CBRF is being paid to provide.

Medically necessary services provided to a recipient in a group setting are covered when they are specific to a recipient and provided as part of the recipient's treatment plan. These include recipient-specific tasks that are not part of the services the community based residential facility, adult foster home, etc., has agreed to provide under other reimbursement are also covered. All caregivers are responsible for coordinating services to avoid duplicate billing. WMAP coverage is primary over county funding.

An individual does not have to be bedridden to be confined to the place of residence. However, the condition of the recipient should be such that there exists an inability to leave home and, consequently, leaving home would require a considerable and taxing effort. If the recipient does in fact leave the home, the recipient may still be considered confined to the residence if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive medical treatment.

It is expected that most absences from the home are for the purpose of receiving medical treatment, such as the ongoing receipt of outpatient kidney dialysis, chemotherapy, or radiation therapy.

An occasional absence from the home for nonmedical purposes, such as an occasional trip to the barber, a walk down the block, attending religious activities, or a drive in a car, would not necessarily disqualify a person from being confined to the place of residence.

C. PLAN OF CARE (POC)

The following general requirements must be met for home health services and private duty nursing services (HSS 101.03[124m], Wis. Admin. Code).

In enacting the Medical Assistance program, Congress recognized that the physician would play an important role in determining service utilization. The Social Security Act and Wisconsin Administrative Code state that reimbursement may be made only if a physician certifies the need for the services and establishes a written POC.

C. PLAN OF CARE (POC)
(continued)

A written plan of care for a recipient is prescribed and periodically reviewed by a physician. The plan of care is developed in consultation with the provider. If a physician refers a recipient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan. The plan of care must include:

- all pertinent diagnoses, including mental status;

- type of services and equipment required;

- methods for delivering needed care, and an indication of which, if any professional disciplines

are responsible for delivering the care;

- an identification of all other parties providing care to the recipient and the responsibilities of each party for that care;
- frequency of visits;
- prognosis;
- measurable time-specific goals;
- rehabilitation potential;
- functional capabilities and limitations, including mental status, dietary needs and allergies;
- activities permitted;
- nutritional requirements;
- medications and treatments;
- any safety measures to protect against injury;
- instructions for timely discharge or referral;
- therapy services that include specific procedures and modalities to be used and the amount, frequency, and duration;
- any equipment and supplies needed; and
- any other appropriate items.

The POC forms that are required by the WMAP are the HCFA 485, 486, and 487. Refer to Appendices 5 through 8 of this handbook for sample POC forms and completion instructions. The WMAP and the provider are responsible for assuring that the services are reasonable and necessary.

Providers may use the Home Care Assessment Form in those situations where a HCFA 486 is required for home health aide services.

The recipient's health status and medical need, as reflected in the POC, provide the basis for determinations as to whether services provided are reasonable and necessary. The primary diagnosis for a recipient must be the current diagnosis which has resulted

C. PLAN OF CARE (POC) (continued)

in the need for the services. It is important that a detailed description of the recipient's medical condition and needs is included in these forms and the information is complete, accurate, and truthful. The POC must be developed and reviewed concurrently with and in support of other health sustaining efforts for the recipient in the home.

Home health services and private duty nursing services must be provided according to the POC, which must be signed and dated by the physician. If multiple physicians order services, orders are combined on one POC, and signed by the primary physician. The primary physician must review the POC at least every 62 days. The home health agency has the responsibility to document that the physician reviews the POC at least every 62 days, that the POC is complete, and for keeping a current and complete POC on file.

When the recipient's medical needs change, the physician is notified and the POC is changed to reflect the recipient's current medical needs. The POC is amended with the interim physician's order. When

the home health agency receives any oral order from the physician, the home health agency must immediately record and sign the oral order. The home health agency must obtain the physician's counter signature within 10 days.

In order to determine whether the nursing services are private duty nursing hours or home health nursing visits, the total anticipated hours of direct, skilled nursing services per calendar day must be indicated on the POC. The total amount of direct skilled nursing services required by the recipient according to the POC must equal the total amount of direct, skilled nursing services provided by all caregivers. This includes the skilled nursing care provided by other caregivers, including another home health agency, nurse or by family or friends in lieu of licensed nurse services. When determining the amount of care contributed by family or friends, only nursing care must be counted. Do not count time spent on parenting or supervision. Refer to Section II-E and II-F of this handbook for further information concerning the definition of skilled nursing services.

When two or more providers share a case, each POC must reflect the orders for the care provided by the provider submitting the POC. Each POC must identify the care provided by the other caregivers, including another home health agency, private duty nurses, and family members. Refer to Appendices 5 through 8 of this handbook for sample POC forms and completion instructions.

D. PRIVATE DUTY NURSING SERVICES

Definition of Private Duty Nursing Services

Private duty nursing services are medically necessary skilled nursing services for a recipient who requires eight or more hours of direct, skilled nursing services per calendar day. This includes the skilled nursing care provided by another home health agency, nurse, or by family or friends in lieu of licensed nurse services (HSS 101.03[134m] and HSS 107.12, Wis. Admin. Code).

Refer to Section II-E and II-F of this handbook for further information on skilled nursing services.

In determining the number of hours of skilled nursing services a recipient requires, pretend that your agency is responsible for all services in a 24-hour period. Then, determine how many hours you would assign to a registered nurse or licensed practical nurse. The total of these hours is the number you must use to determine if the recipient qualifies for private duty nursing.

D. PRIVATE DUTY NURSING SERVICES (continued)

Confinement Limitations

A recipient does not have to be confined to the residence in order to receive private duty nursing services.

Place of Service

Place of service is where services must be provided in order to be covered. Private duty nursing services may be provided both inside and outside of the recipient's residence. However, a recipient must first need nursing services provided in the residence. Hospital inpatient and nursing facilities are not allowable places of services while the recipient is receiving services in those facilities.

Private Duty Nursing Visits

Private duty nursing service has two types of visits, under four procedure codes:

1. Private Duty RN Visit - each hour of service provided by an RN.
2. Private Duty LPN Visit - each hour of service provided by an LPN.

Reasonable time for record keeping, travel, staff training, supervision, and case management are allowable costs which have been included in the rates established for private duty nursing hours. Therefore, the time spent on these activities is not separately reimbursable.

An individual nurse (except in unusual circumstances) may not provide more than 12 continuous hours

in each 24-hour period nor more than 60 hours per week (seven-day period) for all recipients under the nurse's care.

All private duty nursing services must receive prior authorization approval before the services are provided. Refer to Section III of this handbook for information on prior authorization requirements. Refer to Section VIII of Part A of the WMAP Provider Handbook for information on obtaining retroactive prior authorization for special circumstances.

E. HOME HEALTH NURSING SERVICES

Definition of Home Health Nursing Services

Home health nursing services are medically necessary skilled nursing services for a recipient who requires less than eight hours of direct, skilled nursing services per calendar day, as documented on the POC. This includes the skilled nursing care provided by another home health agency, private duty nurse, or by family or friends in lieu of licensed nurse services (HSS 101.03[111r] and HSS 107.11[2], Wis. Admin. Code).

Home health nursing is also referred to as part-time, intermittent skilled nursing services. Part-time, intermittent skilled nursing services means skilled nursing services that are provided in the home for less than eight hours in a calendar day.

In determining the number of hours of skilled nursing services a recipient requires, pretend that your agency is responsible for all services in a 24-hour period. Then, determine how many hours you would assign to a registered nurse or licensed practical nurse. The total of these hours is the number you must use to determine if the recipient qualifies for home health nursing. A recipient who qualifies for private duty nursing does not qualify for home health nursing services.

E. HOME HEALTH NURSING SERVICES (continued)

In accordance with licensure requirements, LPN's must be supervised by an RN or a physician. LPN's will not be reimbursed for complex care (as defined in Admin. Code N6) and IV therapy.

Skilled Nursing Services

In determining whether a service is skilled (i.e., requires the skills of an RN or LPN), consider both the inherent complexity of the service, the condition of the recipient, and accepted standards of medical and nursing practice. Some services are classified as skilled nursing services on the basis of the complexity of the services alone, such as intravenous and intramuscular injections or insertion of catheters. However, the recipient's condition may be such that a service which would ordinarily be considered unskilled may be considered a skilled nursing service because the service can only be safely and effectively provided by a skilled nurse.

Examples of Circumstances in Which Skilled Nursing Services May be Required

Two circumstances in which skilled nursing services may be required for services which might ordinarily be considered unskilled care:

1. A broken leg does not necessarily indicate a need for skilled care. However, if the recipient has a pre-existing circulatory condition, skilled nursing may be needed to observe for complications, to monitor medication administration for pain control, and to incidentally teach proper ambulation techniques to ensure proper bone alignment and healing.

2. The condition of a recipient who has irritable bowel syndrome, or who is recovering from rectal surgery, may be such that he can be given an enema safely and effectively only by a

skilled nurse. If the enema is necessary to treat the medical condition, the visit may be covered as a skilled nursing visit.

However, a service which, by its nature, requires the skills of a licensed nurse to be provided safely and effectively, continues to be a skilled service even if it is taught to the recipient, the recipient's family, or other caregivers. For example, if a recipient was discharged from the hospital with an open draining wound which requires irrigation, packing, and dressing twice each day, the care is skilled nursing care, even if the family is taught to perform the care and provides it part or all of the time.

While some services may be provided by a licensed nurse, they may not be WMAP reimbursable as WMAP skilled nursing services. For instance, services provided by a skilled nurse due to the unavailability of a competent home health aide or personal care worker to provide the nonskilled services, regardless of the importance of the services to the recipient, are not reimbursable as skilled nursing services.

Reasonable and Medically Necessary Services
The skilled nursing service must be reasonable and medically necessary to the diagnosis and treatment of the recipient's current medical condition.

To be considered reasonable and medically necessary for the diagnosis or treatment of the recipient's current medical condition, the services must be consistent with the nature and severity of the medical condition, the recipient's medical needs, and accepted standards of medical and nursing practice.

The determination of whether a recipient needs skilled nursing services should be based solely on the recipient's unique condition and individual needs, without regard to whether the medical condition is acute, chronic, terminal, or expected to extend over a long period of time. In addition, skilled nursing services may continue to be necessary for a recipient whose condition is stable, depending on the unique condition of the recipient.

E. HOME HEALTH NURSING SERVICES (continued)

The following questions need to be asked in determining what are covered skilled nursing services. First, can the services be furnished safely and effectively without the skills of a nurse or a caregiver who has been trained in the specific skilled nursing tasks? If the answer is no, the documentation on the POC should support this response. Second, is the service consistent with the recipient's medical condition and accepted standards of practice? If the answer is yes, the documentation on the POC should support this response.

Confinement Limitations
A recipient must be confined to the residence unless intermittent, medically necessary, covered skilled home health nursing services are required by a recipient who cannot reasonably obtain the service outside of the residence or from a more appropriate provider. Refer to Section II-B of this handbook for the definition of a residence.

Intermittent medically necessary skilled nursing services may include, but are not limited to:

- changing or irrigating an indwelling urinary catheter;
- deep wound care;
- IV therapy;
- injected medications; and
- gastronomy tube feedings and tracheostomy care.

Place of Service
Place of service is where services must be provided in order to be covered. All WMAP-covered home health nursing services must be provided in the recipient's home. Home health nursing services provided to recipients outside of the home are not a benefit.

Home Health Nursing Visits
Within home health nursing services, there are two types of home health visits:

1. Home Health Nursing Initial Visit - the recipient's first home health nursing visit of any duration by an RN or LPN in a calendar day. Only one initial visit is reimbursable per calendar day per recipient, regardless of the number of providers.

2. Home Health Nursing Subsequent Visit - each additional home health nursing visit of any duration following the initial visit per calendar day.

A visit begins when the RN or LPN enters the residence to provide a covered service. The visit ends when the RN or LPN leaves the residence at the conclusion of the covered service.

Home health nursing visits are not reimbursed for the same date of service as Personal Care Supervisory visits.

Prior authorization is required for all home health visits (nursing, home health aide and therapy) when the total of any combination of home health visits (nursing, home health aide and therapy) per recipient, regardless of provider, exceeds 30 visits per calendar year. Refer to Section III of this handbook for information on prior authorization requirements.

F. GUIDANCE CONCERNING MEDICALLY NECESSARY SKILLED NURSING SERVICES

(Private duty and home health nursing services)

General Requirements

Under this section, all limitations of private duty and home health nursing services covered in Section II-D and Section II-E apply. The following guidance illustrates reimbursable skilled nursing services and identifies additional limitations.

Intake Evaluations

Federal regulations require home health agencies to have written policies concerning the acceptance of recipients by the agency. When personnel of the agency make an intake evaluation visit, the cost of the visit is considered an administrative cost of the agency and is not reimbursable separately as a skilled nursing visit, since at this point the recipient has not been accepted for care.

If, however, during the course of this intake evaluation visit, the recipient is determined suitable for home health care by the agency, and is also furnished the first skilled nursing service as ordered under the POC, the visit would become the first reimbursable skilled nursing visit.

Assessments

Reimbursable Assessments

Assessment of a recipient's condition is always a part of required nursing supervision. However, the assessment of the recipient's condition may be reimbursable as skilled nursing services when:

1. The recipient's medical condition requires skilled nursing personnel to identify and evaluate the need for possible modification of treatment. This may include when the following indications are present and documented: abnormal or fluctuating vital signs, weight changes, edema, symptoms of drug toxicity, abnormal or fluctuating lab values, or respiratory changes on auscultation.

   A one-time visit by a registered nurse may be medically necessary to assess and evaluate the medical condition of the recipient in response to contact by a home health aide, personal care worker, the recipient or the recipient's family, or another person expressing concern that the

recipient's medical condition may have changed. This assessment visit may be covered whether or not the visit results in intervention or a change in the care plan. Providers may request an amendment to a prior authorization to cover this visit.

2. The recipient's medical condition requires skilled nursing personnel to initiate additional medical procedures until the recipient's treatment regimen stabilizes, but is not part of a longstanding pattern of care.

   A recipient often requires skilled nursing assessment during the first 30 days following hospital discharge, or until the recipient's medical condition and treatment regimen stabilizes.

3. There is a likelihood of complications or an acute episode requiring skilled nursing personnel to identify and evaluate the recipient's need for possible modification of treatment or initiation of additional medical procedures until the recipient's treatment regimen is essentially stabilized.

   When a recipient is admitted to home health care for assessment because there is reasonable potential of a complication or further acute episode, the skilled assessment services are covered only for as long as there remains a reasonable

F. GUIDANCE CONCERNING MEDICALLY NECESSARY SKILLED NURSING SERVICES
(Private duty and home health nursing services) (continued)

potential for such a complication or acute episode. Medical record documentation must support the likelihood of a future complication or acute episode.

Examples of Reimbursable Assessments

1. A recipient with arteriosclerotic heart disease with unstable congestive heart failure requires close observation by skilled nursing personnel for signs of decompensation, or adverse affects from prescribed medication. Skilled assessment is needed to determine whether the drug regimen should be modified or whether other therapeutic measures should be considered until the recipient's treatment regimen is essentially stabilized.

2. A recipient has undergone peripheral vascular disease treatment, including a bypass. The incision area is showing signs of potential infection and recipient has elevated body temperature. Skilled assessment of the vascular supply of the legs and the incision site is necessary until the signs of potential infection have abated and there is no longer a reasonable potential of infection.

3. A recipient was hospitalized following a heart attack and is discharged home following treatment, but before mobilization. Since it is not known whether exertion will exacerbate the heart disease, skilled assessment is reasonable and necessary as mobilization is initiated until the recipient's treatment regimen is essentially stabilized.

Reimbursable Ongoing Assessment Visits

When an assessment visit does not meet the above guidelines for medical necessity, it may be covered as an ongoing assessment (Title 19 re-evaluation) visit. An ongoing assessment visit is covered when:

- the recipient's medical condition is stable (a medical condition is considered stable when the recipient's physical condition is non-acute, without substantial change or fluctuation at the current time);

- the recipient has not received a covered skilled nursing service, covered personal care service, or covered home visit by a physician within the past 62 days; and

- a skilled assessment is required to re-evaluate the continuing appropriateness of the plan of care.

In accordance with federal Medicaid regulations, the visit must be ordered by a physician in order to be covered. In the ongoing assessment visit, the registered nurse:

- assesses the recipient's current medical condition (including systems assessment, environmental assessment, psycho-social assessment, and functional assessment);

- evaluates the recipient's progress or lack of progress towards meeting established goals; and

- modifies the plan of care as needed.

F. GUIDANCE CONCERNING MEDICALLY NECESSARY SKILLED NURSING SERVICES (Private duty and home health nursing services) (continued)

The ongoing assessment visit is to be used to assess the recipient who is only receiving home health aide services or home health aide and therapy services. Persons receiving covered skilled nursing visits or personal care supervisory visits must be assessed during those covered visits. Skilled nursing services include: private duty RN or LPN; private duty/ventilator dependent RN or LPN; respiratory care RN or LPN; initial or subsequent home health nursing visits; and personal care supervisory visits.

To allow flexibility in scheduling, reimbursement for ongoing skilled nursing assessment and visit will actually be allowed once every 55 calendar days.

Prior authorization is not required for the ongoing assessment visit. Providers must bill using the special ongoing assessment visit procedure code. Refer to Appendix 1 of this handbook for a complete list of procedure codes.

Example of a Non-Reimbursable Assessment or Ongoing Assessment
A physician orders one skilled nursing visit every two weeks and three personal care worker visits each week for bathing and washing hair for a recipient whose recovery from a cerebral vascular accident has caused a residual weakness on the left side. The recipient's condition is stable and the recipient has reached the maximum restoration potential. There are currently no underlying conditions which would necessitate the skilled assessment. An ongoing assessment visit would not be covered in this situation because personal care visits are covered.

Teaching and Training Activities

Reimbursable Teaching and Training Activities
Teaching and training activities which require skilled nursing personnel to teach a recipient, the recipient's family or caregivers how to manage the treatment regimen would constitute skilled nursing services only when provided to a recipient in conjunction with other reimbursable skilled nursing services.

When it becomes apparent after a reasonable period of time that the recipient, family, or caregiver is unwilling or unable to learn or be trained, then further teaching and training ceases to be reasonable and medically necessary. The reason that the recipient, family, or caregiver is unwilling or unable to be trained should be documented in the medical record.

Examples of Reimbursable Teaching and Training Activities

1. A physician has ordered skilled nursing services for a man who was hospitalized for a broken hip and has now been discharged to home. While hospitalized, the recipient was newly diagnosed for diabetes. Skilled nursing care is ordered to closely monitor blood glucose levels until the levels stabilize and to assess understanding of and compliance with a diabetic diet.

   In this case, teaching of self-injection and management of insulin, signs and symptoms of insulin shock and actions to take in emergencies is reasonable and necessary to the treatment of the medical condition, since the recipient is receiving skilled care and cannot reasonably be expected to go to his physician for the instruction.

2. A recipient with arteriosclerotic heart disease with congestive heart failure requires close observation by skilled nurses for signs of decompensation or adverse affects resulting from newly prescribed medication. When visiting the recipient to assess the recipient's

 medical condition, teaching about the medication regimen is appropriate. (Under Wisconsin

CONCERNING MEDICALLY NECESSARY SKILLED NURSING SERVICES
(Private duty and home health nursing services)
(continued)

pharmacy law and Medical Assistance regulations, pharmacists must instruct the person picking up a prescription about the medication, including instructions for administration and signs of adverse reactions. In most cases, the person obtaining the prescription may also obtain this information over the phone.)

Administration of Medications
Administration of legend drug products by a nurse may be covered if it is reasonable and medically necessary to the treatment of the recipient's medical condition and the recipient is not capable of self-administration. A "legend" drug product is one that the Food and Drug Administration requires to carry a label stating the product may only be dispensed with a physician's prescription, under 21USC353(b).

Non-Reimbursable Medication Administration
A skilled nursing visit to ensure compliance with the medication program of an adult recipient who has a demonstrated history of non-compliance over 30 days is a non-covered service.

Medication administration to a minor child is a noncovered parenting task unless the parents are unable to administer the medication.

A skilled nursing visit to administer a medication to an adult recipient who is capable of self-administering the medication, but chooses not to, is not a covered service. A recipient is deemed "capable" if the recipient has no physical or mental condition which would prevent the recipient from self-administering the medication.

Intravenous, Intramuscular, or Subcutaneous Injections and Infusions, and Hypo-dermoclysis or Intravenous Feedings
These services require the skills of a nurse to be performed safely and effectively. The medication being administered must be accepted as safe and effective treatment of the recipient's medical condition, and there must be a medical reason that the medication cannot be taken orally.

The frequency and duration of the administration of the medication must be within accepted standards of medical practice, or there must be a valid explanation regarding the extenuating circumstances which justify the need for additional injections.

1. Insulin injections

   These injections by a skilled nurse are not usually reasonable and medically necessary skilled nursing services, since insulin is customarily self-injected by recipients or injected by their families, although assistive devices may sometimes be required. However, when a recipient is confined to the home and is either physically or mentally unable to self-inject insulin, even with the aid of assistive devices, and there is no other person who is able and willing to inject the recipient, the injections would be considered a reasonable and necessary skilled nursing service.

2. Vitamin B-12 injections

   Vitamin B-12 injections are considered specific therapy only for the following conditions:

F. GUIDANCE CONCERNING MEDICALLY

- alcohol neuropathies;
- anemia, post-gastrectomy syndrome;
- anemia, megaloblastic;

NECESSARY SKILLED NURSING SERVICES
(Private duty and home health nursing services)
(continued)

- anemia, fish tapeworm;
- anemia, pernicious;
- anemia, post-bowel resection;
- anemia, macrocytic;
- cancer of stomach, liver, intestines, and colon;
- strictures of small intestine;
- anastomosis or partial resection of small intestines;
- posterolateral sclerosis;
- sprue or other malabsorption states;
- blind loop syndrome; or
- Crohn's disease.

Oral Medications

The administration of oral medications to a recipient is not a reasonable or medically necessary skilled nursing service except when the complexity of the recipient's condition, the nature of the drugs prescribed, and the number of drugs prescribed require the skills of a licensed nurse to detect and evaluate side effects or reactions. The medical record must document the specific circumstances that cause administration of an oral medication to require skilled observation and assessment.

Eye Drops and Topical Ointments

The administration of eye drops and topical ointments does not require the skills of a licensed nurse. Therefore, even if the administration of eye drops or ointments is necessary to the treatment of an illness or injury and the patient cannot self-administer them, and there is no one available to administer them, the visits cannot be covered as a skilled nursing service. However, administration can be provided during a covered skilled nursing visit for observation and assessment of the recipient's condition.

Tube Insertions and Feedings

Nasogastric, gastrostomy, and jejunostomy tube feeding are covered services. Replacement, stabilization and suctioning of the tubes are also covered skilled nursing services.

If the feeding of a recipient via gastrostomy or jejunostomy tube is delegated to an LPN or aide, medical record documentation must support that the LPN or aide has been instructed in all aspects of tube feeding. This delegation may occur only when deemed appropriate by the registered nurse after assessment of the recipient's medical condition.

Nasopharyngeal and Tracheostomy Suctioning

These are skilled nursing services and are covered as skilled nursing services if they are required to treat the recipient's medical condition.

Catheters

Insertion and sterile irrigation and replacement of indwelling urinary catheters and care of suprapubic catheters are considered skilled nursing services. When the catheter is necessitated by a permanent or temporary loss of bladder control, medically necessary skilled nursing services which are provided at a frequency appropriate to the type of catheter in use are covered. Absent complications, Foley catheters generally require skilled service once every 30 days

F. GUIDANCE CONCERNING MEDICALLY NECESSARY SKILLED NURSING SERVICES
(Private duty and home

and silicone catheters generally require skilled service once every 60-90 days. More frequent care may be covered if documentation supports the medical necessity. This frequency of service is considered reasonable and necessary. In some instances, there are complications which require more frequent skilled services related to the catheter.

If intermittent catheterization is delegated to an LPN or aide by the RN, medical record documentation

health nursing services) (continued)

must support that the LPN or aide has been taught the procedures and has demonstrated competence in the procedures.

Wound Care

Wound care, including but not limited to ulcers, burns, pressure sores, open surgical sites, fistulas, tube sites, and tumor erosion sites, is a skilled nursing service when the skills of a licensed nurse are needed to safely and effectively care for the wound. For skilled nursing care to be reasonable and necessary to treat a wound, the grade, size, depth, nature of drainage (color, odor, consistency, and quantity), condition, and appearance of the surrounding skin of the wound must be documented in the POC. This allows an assessment of the need for skilled nursing to be made.

Descriptions of wound grades or stages may be found in nursing text books. A brief summary follows:

Stage I - partial thickness ulceration limited to epidermis. Inflammatory relation affects all soft tissue.

Stage II - all soft tissue layers are involved. The full thickness lesion extends to subcutaneous fat.

Stage III - progression of the ulceration is deeper with extensive involvement of fat. Deep fascia limits the ulceration. Undermining of the skin and muscle, periosteum, and joint.

The POC must contain the specific instructions for the wound treatment. Where the physician has ordered appropriate active treatment (e.g. sterile or complex dressings, administration of prescription medications, etc.) of wounds with the following characteristics, the skills of a licensed nurse are reasonable and necessary:

1. Open wounds which are draining purulent or colored exudate or which have a foul odor present and/or for which the recipient is receiving antibiotic therapy;

2. Wounds with a drain or T-tube which requires shortening or movement of such drains;

3. Wounds which require irrigation or instillation of a sterile cleansing or medicated solution into several layers of tissue and skin and/or packing with sterile gauze;

4. Recently debrided ulcers;

5. Pressure sores (decubitus ulcers) which present the following characteristics:

   - Partial tissue loss with signs of infection, such as foul odor or purulent drainage;
   - Full thickness tissue loss that involves exposure of fat or invasion of other tissue, such as muscle or bone;

6. Wounds with exposed internal vessels or a mass which may have a proclivity for hemorrhage when a dressing is changed (e.g. post radical neck surgery, cancer of the vulva);

7. Open wounds or widespread skin complications following radiation therapy, or which result from immune deficiencies or vascular insufficiencies;

F. GUIDANCE CONCERNING MEDICALLY NECESSARY SKILLED NURSING SERVICES (Private duty and home health nursing services) (continued)

8. Post-operative wounds where there are complications, such as infection or allergic reaction, or there is an underlying disease which has a reasonable potential to adversely affect healing (e.g. diabetes);

9. Third degree burns, and second degree burns, where the size of the burn or presence of complications causes skilled nursing care to be needed;

10. Skin conditions which require application of nitrogen mustard or other chemotherapeutic medication which present a significant risk to the recipient;

11. Other open or complex wounds which require treatment that can be safely and effectively provided only by a licensed nurse; or

12. For skilled nursing services to continue, there must be on-going medical record documentation of the grade, size, depth, nature of drainage, condition, and appearance of surrounding skin.

13. Skilled nursing care is ordinarily not required for wounds or ulcers that show redness, edema and induration, at times with epidermal blistering or desquamation.

Wound care relates to the direct, hands-on skilled nursing care provided to recipients with wounds, including any necessary dressing changes on those wounds. While a wound might not require this skilled nursing care, the wound may still require skilled monitoring and assessment for signs and symptoms of infection or complication.

Ostomy Care
Ostomy care during the post-operative period and in the presence of associated complications where the need for skilled nursing care is clearly documented is a skilled nursing service. Teaching of ostomy care is reimbursable during the time that skilled assessment, or other covered skilled nursing care, is required.

Medical Gasses
Initial phases of a regimen involving the administration of medical gasses (i.e., oxygen, compressed air) which are necessary to the treatment of the recipient's medical condition require skilled nursing care. Services may include skilled observation and assessment of the recipient's reaction to the gasses and teaching of the recipient and family how to properly manage the administration of the gasses.

Venipuncture

Reimbursable Venipunctures
Venipuncture is a skilled nursing service when the collection of the specimen is necessary to the diagnosis and treatment of the recipient's medical condition and when the venipuncture cannot be performed in the course of regularly scheduled absences from the home to acquire medical

F. GUIDANCE CONCERNING MEDICALLY NECESSARY SKILLED NURSING SERVICES (Private duty and home health nursing services) (continued)

treatment. The frequency of visits for venipuncture must be reasonable within accepted standards of medical practice for treatment of the medical condition. Venipuncture is reasonable and necessary when:

1. The treatment is recognized as being reasonable and medically necessary to the treatment of the medical condition. The physician order for the venipuncture should clarify the need for the test when it is not diagnosis/illness specific.

2. The frequency of the testing is consistent with accepted standards of medical practice for continued monitoring and assessment of a diagnosis, medical problem, or treatment regimen. Even when the laboratory results are consistently stable, periodic venipunctures may be reasonable and necessary because of the nature of the treatment.

Reimbursable Venipuncture for Prothrombin
Venipuncture may be reimbursable when:

1. Documentation shows that the dosage is being adjusted and assessment is ordered by the physician.

2. The results are stable within non-therapeutic ranges. There must be documentation of other factors which would indicate why continued assessment is reasonable and medically necessary.

3. The results are stable within the therapeutic ranges. Monthly monitoring may be reasonable and necessary.

Examples of Reasonable and Necessary Venipunctures

1. Captopril may cause side effects, such as leukopenia and agranulocytosis and it is standard medical practice (to the best of the nurse's knowledge) to monitor the white blood cell count and differential count on a routine basis (every three months) when the results are stable and the recipient is asymptomatic.

2. In monitoring phenytoin (e.g., Dilantin) administration, the difference between a therapeutic and a toxic level of phenytoin in the blood is very slight. It is therefore appropriate to monitor the level on a routine basis (every three months) when the results are stable and the recipient is asymptomatic.

3. A recipient with coronary artery disease was hospitalized with atrial fibrillation and was subsequently discharged to the home health agency with orders for anticoagulation therapy. Monthly venipunctures as indicated are necessary to report prothrombin (protime) levels to the physician.

G. HOME HEALTH AIDE SERVICES

Definition of Home Health Aide Services
Home health aide services are services which are needed to maintain the recipient's health or to facilitate treatment of the recipient's medical condition. These services must include at least one medically necessary medically oriented task per visit, which can be safely performed by a home health aide, but cannot be safely performed by a personal care worker as determined by the delegating RN (HSS 107.11(2), Wis. Admin. Code). Providers should refer to WMAP personal care publications for further information regarding the use of personal care services versus home health aide services.

G. HOME HEALTH AIDE SERVICES (continued)

Refer to Section II-H of this handbook for examples of medically oriented tasks.

Confinement Limitations
A recipient does not need to be confined to the residence in order to receive home health aide services.

Place of Service
Place of service is where services must be provided in order to be covered. All WMAP-covered home health aide services must be provided in the home. Home health aide services provided to a recipient outside of the home are not a benefit.

Delegation of Tasks
Each home health aide task must be specifically assigned by an RN. Whenever an RN assigns a task, the RN must determine that the home health aide is trained to perform that task in a manner which will not jeopardize the recipient's health. The provider's registered nurse may delegate a nursing act to a home health aide. Medical acts which have been delegated to a registered nurse by a physician cannot be re-delegated by the registered nurse. Delegation must be in accordance with N6.03 of the

Wis. Admin. Code, which states:

"In the supervision and direction of delegated nursing acts an RN shall:

(a) Delegate tasks commensurate with education preparation and demonstrated abilities of the person supervised;

(b) Provide direction and assistance to those supervised;

(c) Observe and monitor the activities of those supervised; and

(d) Evaluate the effectiveness of acts performed under supervision."

Providers must document that the above conditions are met when medically oriented tasks are delegated to home health aides.

At a minimum, supervision of home health aides must be in accordance with federal Health Care Financing Administration guidelines as regulated by the Bureau of Quality Compliance and must be adequate to assure safe delivery of services. Refer to Section I-B of this handbook for information about supervision requirements.

Home Health Aide Visits
Within home health aide services, there are two types of home health visits:

1. Home Health Aide Initial Visit - the recipient's first home health aide visit of any duration by a home health aide in a calendar day. Only one home health aide initial visit is reimbursable per calendar day per recipient, regardless of the number of providers.

2. Home Health Aide Subsequent Visit - each additional home health aide visit following the initial visit per calendar day.

A visit begins when the aide enters the residence to provide a covered service. The visit ends when the aide leaves the residence. Upon completion of the covered service, multiple visits per day may be covered only when necessary to provide medically necessary time-specific tasks that could not feasibly be provided in one visit or when the provider obtains prior authorization for continuous visits. Examples of time-specific tasks include:

G. HOME HEALTH AIDE SERVICES (continued)

1. Helping the recipient in and out of bed using a hoyer lift.

2. Non-sterile dressing changes provided throughout the day.

Continuous Visits
Continuous visits may be medically necessary when there is a likelihood that immediate medical attention will be required at unpredictable intervals due to a recipient's medical condition and the intervention includes a medically oriented task. Immediate attention means beginning service within five minutes, so there is not enough time for the recipient to call in a home health aide.

When a home health aide initial or subsequent visit in excess of four hours is medically necessary, and providers feel reimbursement for one visit is not sufficient, providers may request prior authorization to enable them to bill for multiple home health aide visits as multiple visits. Providers may not bill multiple visits for continuous home health aide visits without prior authorization.

Prior authorization is required for all home health visits (nursing, home health aide and therapy) when the total of any combination of home health visits (nursing, home health and therapy) per recipient, regardless of provider, exceeds 30 visits per calendar year. Refer to Section III of this handbook for information on prior authorization requirements.

H. COMPONENTS OF HOME HEALTH AIDE SERVICES

Within home health aide services, there are three components: medically oriented tasks, activity of daily living (ADL) tasks and household tasks. Home health aide services must include at least one medically oriented task, per visit, which cannot be safely performed by a personal care worker as determined by the delegating RN. The following examples illustrate reimbursable home health aide services.

Medically Oriented Tasks
Medically oriented tasks are those medically necessary tasks which require some special medical knowledge or skill, including delegated nursing acts. Medically oriented tasks are usually covered for minor children. Medically oriented tasks which may be safely delegated by a registered nurse may be reimbursable home health aide services.

Medically oriented tasks include, but are not limited to:

Medication Administration
"Administer" is defined in the Pharmacy Examining Board Act, Chapter 450.01(1), Wis. Stats, as the direct application of a prescription drug or device, whether by injection, ingestion, or any other means, to the body of a patient.

Medication administration may be covered for an adult recipient when the recipient is unable to self-administer and there is no willing and able caregiver to administer the medication.

Parents typically administer medications to their minor children. However, medication administration may be covered for minor children when the parents are unable to administer the medication. This includes times when parents are not allowed to leave work to administer medications and no other arrangements can be made.

1. General Agency Requirements Applicable to all Medication Administration by Home Health Aides. All home health agencies providing administration of a medication by home health aide must meet the following conditions:

H. COMPONENTS OF HOME HEALTH AIDE SERVICES (continued)

a. The agency has policies and procedures designed to provide safe and accurate administration of medication. These policies must be followed by personnel assigned to administer medications. This must include the required documentation of the name of the medication, the dose, the route of administration, the time of administration, and the identification of the person administering the medication. [42CFR 484.14(e)]

b. There is a written delegation of this nursing act (medication administration) by the registered nurse. [HSS 133.17(3), Wis. Admin. Code]

c. There is documentation that gives evidence of the educational preparation of the caregiver who administers medications. [HSS 133.06(4)(b), Wis. Admin. Code]

d. There is immediate and accessible supervisory support available to the caregiver administering medications. [HSS 133.18(2), Wis. Admin. Code]

e. Recipients must be informed prior to delivery of service, that their medications will be administered by unlicensed personnel. [HSS 133.08(2)(d), Wis. Admin. Code, and 484.10(c)(1)]

f. Supervision and direction of the delegated nursing act meets the requirements of Chapter N6 of the Wisconsin Administrative Code, which states:

"In the supervision and direction of delegated nursing acts, and RN shall:

(1) Delegate tasks commensurate with educational preparation and demonstrated abilities

of the person supervised;

(2) Provide direction and assistance to those supervised;

(3) Observe and monitor the activities of those supervised; and

(4) Evaluate the effectiveness of acts performed under supervision.

2. Administration of Preselected Medication. A home health aide may administer medications to all recipients, regardless of age or functional capacity when all of the following conditions are met:

   - the medication is preselected by a nurse, pharmacist, recipient, or designated family member; and
   - all agency requirements listed previously are met.

3. Administration of Medication that is not Preselected. Administration of medications by home health aides may include selection of the medication and selection of the dose, along with applying the medication to the body of a recipient. The act of administration of medication that has not been preselected may be provided by home health aides only when all of the following conditions are met and documented in the provider's records:

H. COMPONENTS OF HOME HEALTH AIDE SERVICES
(continued)

a. When medication has not been preselected, there is documented evidence that the home health aide has been trained in the actions, uses, effects, adverse reactions, and toxic effects of all medications administered. Additionally, the home health aide must be trained relative to appropriate responses to adverse reactions to any medication administered. The delegating registered nurse must verify the training by doing at least one return demonstration with each home health aide administering medication to a specific recipient. [HSS 133.06(4)(b)(0), Wis. Admin. Code]; and

b. All agency requirements listed previously are met.

Simple Dressing Changes

Some dressing changes do not require the skills of a licensed nurse. Wounds or ulcers that show redness, edema, and induration, at times with epidural blistering or desquamation, do not ordinarily require skilled nursing care. Simple dressing changes may be medically necessary when the physician orders them for the treatment of a wound or sore and no primary caregiver is willing or able to provide the care.

Assistance with Activities Which Are Directly Supportive of Skilled Therapy Services

This includes activities that do not require the skills of a therapist to be safely and effectively performed. Activities may include routine maintenance exercises, e.g., range of motion exercises and repetitive speech routines. In order to be medically necessary, the activities must be ordered in conjunction with an active therapy program or as the direct result of a therapy evaluation completed and signed by a therapist within the past six months. Therapy evaluations must be updated annually in order to verify the continuing medical necessity of activities supportive of therapy, such as range of motion (ROM), repetitive speech routines, and other routine maintenance exercises.

Vital Signs

Taking vital signs may include taking the recipient's temperature, blood pressure, pulse and respiratory rates, and reporting them to the supervising nurse whenever they are outside of the parameters established for the recipient by the physician. Taking vital signs may be medically necessary when the recipient's medical history supports the need for ongoing monitoring for early detection of an exacerbation and the physician establishes parameters at which point a change in treatment may be required.

Glucometer Readings

Taking glucometer readings and reporting them to the supervising nurse whenever the readings are outside of parameters established for the recipient by the physician may be medically necessary when the recipient's medical history supports the need for ongoing monitoring for early detection of readings outside of established parameters. High blood sugars due to the noncompliance of a competent adult do not justify glucometer tests as medically necessary tasks.

Complex Transfers

These are transfers that require the use of special devices when there is an increased likelihood that a negative outcome would result if the transfer is not done correctly, or when a special technique is used as part of a complex therapy program. The following transfer techniques are part of the suggested personal care curriculum and do not qualify as complex transfers: stand-pivot transfer, sliding board, and transfer belts. Complex transfers may be medically necessary when the recipient has no volitional movement below the neck or when simple transfer techniques have been demonstrated to be ineffective and unsafe.

H. COMPONENTS OF HOME HEALTH AIDE SERVICES
(continued)

Complex Positioning

This is positioning to reduce spasticity or positioning a recipient who would require complex repositioning (i.e., Bolsters/Side-Lyers). Complex repositioning may be medically necessary when the recipient has a demonstrated problem with frequent skin breakdowns.

Skin Care

Skin care may be a medically oriented task and medically necessary when legend solutions, lotions, or ointments are ordered by the physician due to skin breakdown, wounds, open sores, etc. PRN or prophylactic skin care is an activity of daily living task, not a medically oriented task.

Feeding

This may be a medically oriented task and medically necessary when there is a potential for aspiration and the physician orders state special procedures or tools must be utilized to effect safe feeding; e.g., oral facilitation (one teaspoon bolus of food positioned in special section of mouth).

Feeding via a gastrostomy tube may be a medically oriented task when delegated by the registered nurse, and when it is deemed appropriate after assessment of the recipient's medical condition and the home health aide's training.

Application of Prosthesis or Orthosis

This may be a medically oriented, medically necessary task when part of a serial splinting program or when the recipient has a demonstrated problem with frequent skin breakdowns which must be closely monitored.

Active Seizure Intervention

Active seizure intervention, including safety measures, reporting seizures, and administration of medication at the time of the active seizure, etc., may be a medically oriented task. Active seizure intervention does not include administration of routine anti-seizure medication. Active seizure intervention may be medically necessary when the recipient has had active seizures, requiring active intervention, within the past 62 days.

ADL Tasks Performed By A Home Health Aide
Activity of daily living (ADL) tasks for pre-school children are services typically provided by parents, but less typically for school-age children. Upon reaching school age, some independence with ADL tasks is typically attained. Therefore, ADL tasks are usually covered for school-age children, but are seldom covered for pre-school children. ADL tasks provided to pre-school children may be covered when the tasks require special skills to assure safety or are provided incidental to a medically oriented task.

Mobility

1. Assistance with mobility and ambulation, including use of walker, cane, or crutches.

2. Assistance with simple transfers, including bed to chair or wheelchair and reverse.

3. Assistance with getting in and out of bed.

H. COMPONENTS OF HOME HEALTH AIDE SERVICES
(continued)

4. Simple turning and repositioning.

5. Assistance with exercise program which is not ordered by a therapist in conjunction with active therapy.

Toileting

1. Assistance with toileting.
2. Bowel and bladder care.

Hygiene

1. Bathing.
2. Dressing and undressing.
3. Hair care, including shaving.
4. Oral hygiene, including teeth, mouth, and denture care.
5. Skin care, excluding wound care.
6. Care of eyeglasses and hearing aides.
7. Nail care, excluding nail care of diabetic recipients.

Nutrition

1. Assistance with nutrition and diet activities.
2. Assistance with feeding when there are no special procedures or tools utilized.

Medication
Assistance with self-administration, such as opening container or steadying recipient's hand.

Household Tasks
When a home health aide visits a recipient to provide a medically oriented service, the home health aide may also perform some household tasks. Provision of household tasks must be incidental to medically oriented tasks and personal care tasks, and must not be the primary reason for the home health aide visit.

Household tasks are typically provided by parents for their minor children. Most household tasks provided to minor children are not covered. Incidental household tasks may be covered only when the tasks are incidental to covered medically oriented or ADL tasks.

Examples of Household Tasks

1. Changing bed.
2. Cleaning equipment.
3. Maintenance, including cleaning, of prosthetics and orthotics.
4. Food preparation and cleaning of dishes.
5. Laundry of bed linens and recipient's personal clothing.
6. Light housekeeping of areas used directly by the recipient.

I. THERAPY SERVICES

Definition of Therapy Services

Medically necessary skilled therapy services are covered by the WMAP. The specific therapies are occupational therapy, physical therapy, and speech and language pathology (HSS 107.11(2), Wis. Admin. Code).

I. THERAPY SERVICES (continued)

The WMAP requires certified therapy assistants to receive supervision by a certified therapist who is physically present at the residence.

Skilled Therapy Services

The service of a physical therapist, occupational therapist, or speech and language pathologist is a skilled therapy service if the inherent complexity of the service is such that it can only be performed safely and effectively by a skilled therapist. To be covered, the skilled services must also be reasonable and necessary to the treatment of the recipient's medical condition or to the restoration or maintenance of function, or to manage services provided.

Therapy Evaluation

In addition to the POC, a therapy evaluation must be made prior to provision of therapy services. The evaluation must be reviewed, signed, and dated by the *performing therapist*, who must be identified as such on the evaluation. The evaluation must include specific measurable goals which reflect the chronological or developmental age of the recipient. The evaluation must include written instructions for follow through or carryover by the recipient and/or caregiver. Carryover or follow through must be realistically achievable by the recipient and/or caregiver at the place of residence.

Reasonable and Medically Necessary Therapy Services

The skilled therapy services must be reasonable and necessary within the context of the recipient's medical condition. The services must be consistent with the nature and severity of the medical condition and the recipient's particular medical needs. This includes the requirement that the amount, frequency, and duration of the services must be medically necessary and does not duplicate other services provided.

The services must be considered, under accepted standards of medical practice, to be specific and effective treatment for the recipient's condition. The services must be provided with the expectation, based on the physician's assessment of the recipient's rehabilitation potential, that: 1) the condition of the recipient will improve materially in a reasonable and generally predictable period of time, or 2) the services are necessary to the establishment of a safe and effective maintenance program.

Examples of Reimbursable Therapy Visits

1. A recipient with a diagnosis of multiple sclerosis has recently been discharged from the hospital following an exacerbation of her condition which has left her wheelchair bound and, for the first time, without any expectation of achieving ambulation again. The physician has ordered occupational therapy to select the proper wheelchair for her long term use, to teach safe use of the wheelchair and safe transfer techniques to the recipient and the family. Occupational therapy would be reasonable and necessary to evaluate the recipient's overall needs, to make the selection of the proper wheelchair, and to teach the recipient and/or family safe use of the wheelchair and proper transfer techniques and other self-care activities.

2. A physician prescribes physical therapy treatments three times a week for 45 days for a recipient who has been discharged from the hospital following a recent hip fracture. The recipient was discharged using a walker for seven days from the start of home care. Documentation on the HCFA 486 shows that the recipient was discharged from the hospital with restricted mobility in ambulation, transfers,

I. THERAPY SERVICES
(continued)

and climbing of stairs. The recipient had an unsafe gait which indicated a need for gait training and the recipient had not been instructed in stair climbing and a home exercise program. The goal of the physical therapy was to increase strength, range of motion, and to progress from walker to cane with safe gait. The services are reasonable and necessary for the recipient's medical condition.

Multiple Therapies
If a recipient requires multiple therapies and each therapy has a unique approach to the individual's treatment, then therapies should be separately and independently provided to give the recipient the maximum benefit and opportunity for rehabilitation.

Confinement Limitations
A recipient must be confined to the residence in order to receive WMAP-covered therapy services. Refer to Section II-B of this handbook for definition of a residence, unless the recipient cannot reasonably obtain the services outside the residence or from a more appropriate provider.

Place of Service
Place of service refers to where services must be provided in order to be covered. All WMAP-covered therapy services must be provided in the recipient's place of residence except when federal regulations allow services to be provided elsewhere due to the need for special equipment.

Home Health Therapy Visits
Within therapy services there are three types of home health visits: home health occupational therapy, home health physical therapy, and home health speech and language pathology. A therapy visit is a visit of any duration by a physical therapist, occupational therapist, or speech and language pathologist for a period of therapy service. Only one occupational therapy visit, physical therapy visit, and speech and language pathology visit, per recipient, per day, is reimbursable.

A visit begins when the therapist enters the residence to provide a covered service. The visit ends when the therapist leaves the residence.

Prior authorization is required for all home health visits (nursing, home health aide and therapy) when the total of any combination of home health visits (nursing, home health aide and therapy) per recipient, regardless of provider, exceeds 30 visits per calendar year. Refer to Section III of this

handbook for information on prior authorization requirements.

J. GUIDELINES CONCERNING MEDICALLY NECESSARY HOME HEALTH THERAPY SERVICES

Therapy services are covered only if the recipient's abilities are not functional for the recipient's way of life at the current time.

The therapy plan must contain clear and measurable goals which are appropriate to the recipient's chronological or developmental age, way of life, and home situation. The therapy goals must be medical in nature, rather than educational, social, or vocational in nature.

Services involving activities for the general welfare of a recipient, e.g., general exercises to promote overall fitness or flexibility, and activities to provide diversion or general motivation, do not constitute skilled therapy.

The recipient must show motivation, interest or desire to participate in therapy. The frequency and amount of therapy should depend on the recipient's demonstrated response to current therapy and/or estimated response to proposed therapy.

J. GUIDELINES CONCERNING MEDICALLY NECESSARY HOME HEALTH THERAPY SERVICES (continued)

The recipient must show progress toward meeting or maintaining established measurable goals or show carryover (follow-through of activities or skills learned) within six months of treatment at home.

Services of skilled therapists which are for the purpose of teaching the patient or the patient's family or caregivers necessary techniques, exercises, or precautions are covered to the extent that they are reasonable and necessary to treat the medical condition and direct care is provided in conjunction with the teaching.

Visits made by skilled therapists to a recipient's home solely to train other home health agency staff are not billable as visits, since the home health agency is responsible for ensuring that its staff is properly trained to perform any service it furnishes. The costs of a skilled therapist's visit for the purpose of training home health agency staff is an administrative cost to the home health agency.

Therapy which requires only the use of equipment without the skills of a therapist is not covered. Group therapy is not covered.

K. DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment (DME) means equipment which can withstand repeated use, is primarily used for medical purposes, is generally not useful to a person in the absence of illness or injury and is appropriate for use in the home.

DME is covered only when prescribed by a physician. Covered services are limited to items contained in the Wisconsin Durable Medical Equipment Index. There are items in the DME Index that need prior authorization. Refer to Section III of this handbook for information on prior authorization requirements for DME.

L. DISPOSABLE MEDICAL SUPPLIES

Disposable Medical Supplies (DMS) means disposable, consumable, expendable or nondurable medically necessary supplies which have a very limited life expectancy. Routine supplies used by a home health agency that are not recipient-specific, such as disposable thermometer covers, masks, and gloves used as safety precautions are included in the patient care visit rates and are not separately reimbursable.

M. HEALTHCHECK "OTHER SERVICES"

Under HealthCheck, the WMAP will cover medically necessary health care, diagnostic services, treatment and other measures described in the Medical Assistance section of the Social Security Act which are to correct or ameliorate defects and physical and mental illnesses and conditions discovered during a HealthCheck screening of a recipient under age 21, whether or not such services are covered under the Medical Assistance State Plan. This may include necessary health care services which are not otherwise covered or which exceed existing WMAP limitations.

As with all Medical Assistance services, the WMAP has the authority to review the medical necessity

of all requests, establish criteria for the provision of such services, and determine the amount, duration, and scope of services so long as the limitations are reasonable and maintain the preventive thrust of HealthCheck. All HealthCheck "Other Services" require prior authorization. Refer to Section III of this handbook for procedures for submitting a prior authorization request.

N. NONCOVERED SERVICES

Noncovered Home Health Services

The following services are not covered home health services:

1. Services that are not medically necessary.

2. Skilled nursing services provided for eight or more hours per recipient per day.

N. NONCOVERED SERVICES (continued)

3. More than one initial visit per day by a home health skilled nurse, home health aide, physical or occupational therapist or speech and language pathologist.

4. Private duty nursing services under HSS 107.12, Wis. Admin. Code, except in situations when the condition of the recipient of home health nursing services worsens to the point that eight or more hours of direct, skilled nursing care are needed in a calendar day. The nursing services may continue to be billed as home health services for a maximum of 30 days.

5. Services requiring prior authorization that are provided without prior authorization.

6. Supervision of the recipient when supervision is the only service provided at the time. This includes supervision provided to give the primary caregiver a respite from care.

7. Hospice care provided under HSS 107.31, Wis. Admin. Code.

8. Mental health and alcohol or other drug abuse services provided under HSS 107.13 (2), (3), (3m), (4), and (6), Wis. Admin. Code.

9. Medication administration by a personal care worker or administered by a home health aide which has not been delegated by an RN according to the relevant provisions of HSS 133, Wis. Admin. Code.

10. Skilled nursing services contracted for by a home health agency unless the requirements of HSS 133.19, Wis. Admin. Code, are met and approved by the DHSS.

11. Occupational therapy, physical therapy, or speech pathology services requiring only the use of equipment without the skills of the therapist or speech pathologist.

12. Skilled nursing visits:

- solely for the purpose of ensuring that a recipient who has a demonstrated history of noncompliance over 30 days, complies with the medications program;

- to administer or assist with medication administration of an adult recipient who is capable of safely self-administering a medication as determined and documented by the RN;

- to prefill syringes for self-injection when, as determined and documented by the RN, the recipient is capable of prefilling or a pharmacy is available to prefill; and

- to set up medication for self-administration when, as determined and documented by the RN, the recipient is capable or a pharmacy is available to assist the recipient.

13. Home health services to a recipient who is eligible for covered services under the Medicare program or any other insurance held by the recipient;

14. Services that are not medically appropriate. In this paragraph, "medically appropriate" means a service that is a proven and effective treatment for the condition for which it is intended or used;

N. NONCOVERED SERVICES
(continued)

15. Parenting.

16. Services to other members of the recipient's household.

17. A visit made by a skilled nurse, physical or occupational therapist, or speech pathologist solely to train other home health workers.

18. Any home health service included in the daily rate of the community based residential facility where the recipient is residing.

19. Services when provided to a recipient by the recipient's spouse or parent if the recipient is under age 18.

20. Skilled nursing and therapy services provided to a recipient who is not confined to a place of residence when services are reasonably available outside the residence.

21. Any service which is performed in a place other than the recipient's residence.

22. Independent nursing services when a home health agency is available.

Private Duty Nursing Services
The following services are not covered private duty nursing services:

1. Any services not included in the physician's plan of care.

2. Any services under HSS 107.11, Wis. Admin. Code.

3. Skilled nursing services performed by a recipient's spouse or parent if the recipient is under age 21.

4. Services that were provided but not documented.

5. Any service that fails to meet the recipient's medical needs or places the recipient at risk for a negative treatment outcome.

A. GENERAL REQUIREMENTS

Prior authorization procedures are designed to safeguard against unnecessary utilization of care, to promote the most effective and appropriate use of available services, and to assist in containing costs. Providers are required to seek prior authorization for certain specified services before delivery of that service, unless the service is provided on an emergency basis. Prior authorization requests must be submitted no earlier than 62 days prior to the requested grant date, since earlier submission increases the likelihood that the recipient might not require the service by the time the grant date is reached. Providers may request a grant date that results in prior authorization starting before it is required.

Payment is not made for services provided either prior to the grant date or after the expiration date indicated on the approved Prior Authorization Request Form (PA/RF) when prior authorization is required. If the provider renders a service which requires prior authorization without first obtaining authorization, the provider is responsible for the cost of the service.

By requesting prior authorization for services, providers represent to the Department of Health and Social Services (DHSS) that care, to the best of their knowledge, is not available from a volunteer and that the provider will only bill Medical Assistance when the provider believes Medical Assistance is the primary payor. Care actually provided must also have been medically necessary. Providers remain accountable for appropriate utilization of funding they receive on behalf of the recipient. The WMAP will report suspicion of abuse or fraud to the appropriate federal or state agency for investigation.

B. SERVICES REQUIRING PRIOR AUTHORIZATION

General Requirements

Prior authorization is required in the following circumstances:

1. All home health visits (nursing, home health aide and therapy), other than ongoing assessments, when the total of any combination of home health visits (nursing, home health aide and therapy), other than ongoing assessments, by all providers exceed 30 visits in a calendar year.

   Ongoing assessments are not subject to prior authorization and do not count towards the 30-visit home health prior authorization threshold. See Section II-F of this handbook for a definition of ongoing assessment.

2. All home health services when the services are provided in conjunction with private duty nursing or respiratory care services.

3. In shared cases, all visits accumulate toward the 30 visit threshold and if one provider requires prior authorization, all providers require prior authorization.

4. All private duty nursing services.

To determine when prior authorization is required, each visit or hour billed to the WMAP without prior authorization is counted. Visits provided and billed under prior authorization are not counted towards the 30-visit threshold.

B. SERVICES REQUIRING PRIOR

Prior authorization expiration dates do not automatically expire at the end of the calendar year. Prior authorization requests that have expiration dates beyond the end of the calendar year are

AUTHORIZATION (continued)

valid. The prior authorization number indicated on the PA/RF must be used for claim submission. Please be sure to use the prior authorization number on all claims for dates of services that are between the grant and expiration date of the approved PA/RF. Although providers are allowed 30 home health visits in a new calendar year, providers are encouraged to request prior authorization immediately so that reimbursement is not jeopardized.

If the recipient is also receiving personal care services from a home health agency, the agency must request prior authorization for both home health and personal care services on one PA/RF. Services added during the term of the PA/RF must be added by amendment.

Payment for care in excess of 24 hours in a 24-hour period is approved only in one circumstance. This circumstance occurs when it is medically necessary for more than one RN, LPN, home health aide, or personal care worker to provide care simultaneously to a recipient when a primary care provider is not available. Examples include but are not limited to: 1) periodic changing of the entire tracheostomy tube, and 2) periodic transfer or repositioning of a recipient when it could cause harm to that recipient.

Prior authorization is not granted to accommodate provider policy. Prior authorization is only granted to meet specific recipients' needs. Justification for the requested service must be clearly, completely, and truthfully documented on the POC.

Private Duty Nursing Services

All private duty nursing services must receive prior authorization before the services are provided. All home health aide, home health therapy, and respiratory care services require prior authorization when private duty nursing services are provided.

All approved prior authorizations for private duty nursing services will have PRIVATE DUTY NURSING stamped in red ink on the front of the PA/RF to identify recipients receiving this WMAP service.

"PRN"

Providers may only request hours to be used "as needed" (PRN hours) when service is apt to vary from day to day due to changes in the recipient's need for services. A specific number of PRN visits must be requested by procedure code per week, or month of service. These visits must also be included in the POC. PRN visits must be added to the regularly scheduled number of hours requested for that procedure code. The need for PRN visits must be explained based on recipient-centered parameters.

When the provider cannot determine whether a registered nurse or a licensed practical nurse will provide the private duty nursing, the provider must request approval for both by entering both procedure codes on one line of the PA/RF. Separate the procedure codes by a slash. Include a statement that the total number of hours of care does not exceed the total number of hours on the POC.

B. SERVICES REQUIRING PRIOR AUTHORIZATION (continued)

Prior Authorization of Services for Recipients with Changing Needs

If the condition of a recipient of home health nursing services worsens to the point that eight or more hours of direct, skilled nursing care are required in a calendar day, the nursing services may continue to be billed as home health services for a maximum of 30 calendar days. The 30 calendar day limit begins on the first day eight hours or more of skilled nursing services becomes necessary. This is permitted only if all nursing services are provided in the

recipient's residence. This is to allow the provider time to submit a new PA/RF. After 30 days, home health nursing services are not reimbursed. If the recipient reached the prior authorization threshold for home health services as described in this section of the handbook, only home health nursing services that are prior authorized are reimbursable. If skilled nursing services are being provided outside of the home, the provider must obtain prior authorization under private duty nursing services and cannot use the 30-day grace period.

This 30-day period is the only time that services for a recipient requiring eight or more hours of direct, skilled nursing care per calendar day may be billed as home health nursing services. All new admissions must receive prior authorization before private duty nursing services are provided, as described in this section.

When providing private duty nursing services to a recipient whose condition improves to the point that the recipient requires less than eight hours of direct, skilled nursing care in a calendar day, the provider may continue to bill prior authorized private duty nursing services under private duty nursing procedure codes for a maximum of 30 calendar days.

This 30-day period is the only time that services for a recipient requiring less than eight hours of direct, skilled nursing care per calendar day may be billed as private duty nursing services. If the provider does not have a valid private duty nursing prior authorization, no reimbursement can be made under private duty nursing procedure codes. All new admissions are subject to the home health prior authorization requirements described in this section.

An amendment to a prior authorization is never appropriate when a recipient's need for care requires a change from home health nursing to private duty nursing or vice versa. When a change in the care classification occurs, providers must submit a new prior authorization request.

Home Health Services

General Requirements

Prior authorization is required for all home health visits (nursing, home health aide and therapy) when the total of any combination of home health visits (nursing, home health aide and therapy) per recipient exceeds 30 visits per calendar year, regardless of provider. Thus, if a recipient received ten home health aide initial visits, five home health aide subsequent visits, five home health nursing initial visits and 10 physical therapy visits, for a total of 30

visits, prior authorization is required before any further home health services may be provided for reimbursement by the Wisconsin Medical Assistance Program (WMAP). If some visits are made by one provider and the balance of the visits are made by another provider, prior authorization is still required before any further home health services may be provided for WMAP reimbursement.

B. SERVICES REQUIRING PRIOR AUTHORIZATION (continued)

Due to the limited number of visits which may be provided without prior authorization, providers are urged to send in a prior authorization request for each recipient upon completion of the POC.

Shared Cases

For shared cases, the first provider per discipline to arrive at a recipient's home in a calendar day may bill for the initial visit. Additional providers within a discipline must bill for services under the subsequent visit procedure codes regardless of the fact that they might be with a different agency. Cooperation between providers is important to assure appropriate care and reimbursement of shared cases.

Continuous Visits

When a home health aide initial or subsequent visit in excess of four hours is medically necessary and providers believe reimbursement for one visit is not sufficient, providers may request prior authorization to enable them to bill for multiple home health aide visits. The provider must indicate on the PA/RF:

> "Authorization requested to bill for (number of) subsequent HH Aide Visits due to (number of) continuous hours of care."

Both the provider and the recipient may be contacted by state nurse consultants to verify or obtain information regarding the medical necessity of the care. Alternatives to continuous care will also be explored before prior authorization is granted.

In determining the number of continuous home health aide visits that a provider will be allowed to bill, consideration will be given to the recipient's needs and special circumstances, such as the lack of a provider within the recipient's service area. In most situations this will result in approval being granted to bill for one home health aide visit for the first four hours of continuous home health aide services, and one home health aide visit per every three hours thereafter.

"PRN"
Providers may request home health visits to be used "as needed" (PRN visits) when service is apt to vary due to changes in the recipient's need for services. A specific number of PRN visits must be requested by procedure code per week, or month of service. These visits must also be included in the POC. PRN visits must be added to the regularly scheduled number of visits requested for that procedure code. The reason for the PRN visits must be explained based on recipient-centered parameters.

Prior Authorization for Durable Medical Equipment (DME)
Refer to the DME Index for DME items that need prior authorization.

C. PRIOR AUTHORIZATION CRITERIA

The general criteria for prior authorization of private duty nursing and home health services are:

1. All services must be listed as covered services and *not listed* as noncovered services in Chapter HSS 107 of the Wisconsin Administrative Code.

C. PRIOR AUTHORIZATION CRITERIA (continued)

2. The recipient must meet any applicable confinement limitation. All limitations must be met;

3. All services, other than private duty nursing, a personal care worker accompanying a recipient to a medical appointment, or therapy requiring special equipment, must be provided in the recipient's residence;

4. The POC must document that the physician ordered the services no earlier than 62 days prior to receipt by EDS or that the orders are still valid, and must be valid for the start date requested;

5. The prior authorization request must be complete and must demonstrate the medical necessity of the service(s);

6. The request must include only services that are appropriate for the procedure code(s) requested;

7. The services ordered must be appropriate for the training level(s) of the designated care provider(s);

8. The quantity requested must be appropriate for the assigned tasks;

9. Services provided by two or more providers must be coordinated and must reflect identical physician orders; and

10. The services must comply with all state and federal regulations.

D. PROCEDURES FOR OBTAINING PRIOR AUTHORIZATION

Section VIII of Part A of the WMAP Provider Handbook identifies procedures for obtaining prior authorization emergency situations, appeal procedures, supporting materials, retroactive authorization, recipient loss of eligibility midway in services, and prior authorization for out-of-state providers.

A list of all forms that must be submitted with a PA/RF is located in Appendix 2 of this handbook. The sample prior authorization request forms and attachments by discipline are given in Appendix 4 of this handbook.

Private Duty Nursing Services

Providers requesting prior authorization for private duty nursing must use the PA/RF and the POC. Refer to Appendices 3 and 4 of this handbook for a sample PA/RF and completion instructions, and to Appendices 5 - 8 of this handbook for sample POC forms and completion instructions.

Providers must indicate on the PA/RF the expected number of private duty nursing RN hours and private duty nursing LPN hours per day, the number of days per week, and the number of weeks or months of service per discipline. The total number of private duty nursing hours requested must exactly match the number of hours on the POC which the agency has agreed to provide. Services by another provider, whether another home health agency, independent nurse, or volunteer help, in lieu of a licensed nurse, must also be indicated on the POC. PRN hours may also be requested.

D. PROCEDURES FOR OBTAINING PRIOR AUTHORIZATION (continued)

Home Health Nursing and Aide Services

Providers requesting prior authorization for home health visits must use the PA/RF and the POC. Refer to Appendices 3 and 4 of this handbook for a sample PA/RF and completion instructions, and to Appendices 5 - 8 of this handbook for sample POC forms and completion instructions.

Providers must indicate on the PA/RF the expected number of initial and subsequent visits per day, the number of days per week, and the number of weeks or months of service per discipline. The total number of visits requested on the PA/RF per week must exactly match the number of weekly visits on the POC which the agency has agreed to provide. Services by another provider, whether another home health agency, independent nurse, or volunteer help, in lieu of a licensed nurse, must also be indicated on the POC. PRN visits may also be requested.

Therapy Services

Providers requesting prior authorization must use the PA/RF and the Prior Authorization

Home Health Therapy Attachment (PA/HHTA). The POC, therapy evaluation and the Individualized Educational Plan (IEP) [if a school-age child 0-21] must also be attached. Refer to Appendices 3 and 4 of this handbook for a sample PA/RF and completion instructions, Appendices 5 - 8 of this handbook for sample POC Forms and completion instructions, and to Appendices 9 and 10 of this handbook for a sample PA/HHTA and completion instructions.

Providers must indicate on the PA/RF the expected number of home health occupational therapy visits, home health physical therapy visits, and home health speech and language pathology visits per day, the number of days per week, and the number of weeks or months of service per discipline. The total number of visits requested must exactly match the number of visits on the Therapy Evaluation. PRN visits may also be requested.

Providers requesting prior authorization for both therapy services and other home health services (RN, LPN, and/or home health aide) must attach both the PA/HHTA and the POC to a single PA/RF.

Required Prior Authorization Request Information

Prior authorization requests for therapy services which do not contain the following information are returned to the provider:

1. Diagnoses, including chronology, multiplicity and dates of onset.
2. Character of illness: acute, subacute or chronic.
3. Age: currently and at onset of problems.
4. Previous Therapy: dates, frequency, amount, and types.
5. Evaluations with respect to age, problems and potential for achieving stated goals, and re-evaluations appropriate to progress. Re-evaluations must be made at least annually.

D. PROCEDURES FOR OBTAINING PRIOR AUTHORIZATION (continued)

6. Rehabilitation Potential: history including former level of functioning, plans for discharge (i.e., from therapy, from nursing home to community, from group home to apartment); plans for maintenance; status indicating receptiveness to therapy, the probability of meeting realistic goals pertaining to functional status.
7. Progress statement relating therapy treatment progress in specific objective and measurable terms.
8. Information regarding carryover or follow through by the recipient and/or care giver. Carryover and follow through compatible with measurable treatment goals must be documented.

Therapy Services for School Age Children

If therapy is being requested for a school-age child (0-21), an IEP must be submitted for the purpose of coordination and integration of the educational and medical needs of the child, or documentation regarding the reasons for the absence of school therapy must be submitted.

The date on the IEP must be no earlier than nine months prior to receipt by EDS.

Authorization for therapy services may be granted for the entire traditional nine month school year.

Multiple Providers/Therapies
If two providers of the same type (i.e., both occupational therapists from different agencies) request dual treatment for one recipient, each provider must complete a separate PA/RF which are adjudicated together. In addition to completion of the required prior authorization elements, the following information must be added:

1. The purpose of the dual providership;

2. The specific days of the week each provider will administer the service; and

3. The procedure for the coordination of the treatment plan.

Prior Authorization for Durable Medical Equipment
Prior authorization for DME supplied by home health providers must be requested on a separate PA/RF and the Prior Authorization Durable Medical Equipment Attachment (PA/DMEA). Examples of the appropriate prior authorization request forms, along with completion and submittal instructions, are included in Appendices 13 and 14 of this handbook. Prior authorization is only needed for specific items so indicated in the DME Index.

Nonspecific procedure codes, or "not otherwise classified" codes are used only when there is not a distinct procedure code for the service being provided. Whenever possible, use the most specific codes available, rather than general codes.

The maximum allowable reimbursement for not otherwise classified codes are determined when the prior authorization is approved. Reimbursement is then the billed amount or the amount on the PA/RF, whichever is less. Refer to Appendix 15 of this handbook on how to complete PA/RF's for nonspecific procedure codes.

D. PROCEDURES FOR OBTAINING PRIOR AUTHORIZATION (continued)

Amendments
An amendment to an approved PA/RF must be requested whenever the physician orders additional care, unless the services can be billed without a prior authorization number and charged against outstanding prior authorization threshold visits. This includes intermittent additional care due to fluctuations in the availability of the primary caregiver.

Amendments to an approved prior authorization must be submitted on the Prior Authorization Amendment Request Form and should reference the original prior authorization number. A copy of the PA/RF being amended must be attached. See Appendix 2 of this handbook for a complete list of forms to submit with an amendment request. See Appendices 11 and 12 of this handbook for completion instructions and a sample Prior Authorization Amendment Request Form.

A new PA/RF must be submitted when changing nursing services from home health to private duty or vice versa. Do not submit an amendment in these circumstances.

Amendment requests may be backdated two weeks when they cover extraordinary circumstances, such as emergency services or other services whose medical necessity could not have been predicted. Amendment requests also may be backdated to the grant date on the original prior authorization request when:

1. The amendment request is directly related to a modification of the original request and

the amendment request is received by EDS within two weeks of the adjudication date on the original PA/RF; or

2. The amendment request results from an EDS or BHCF error on the original adjudication.

Obtaining and Submitting Prior Authorization Request Forms
Completed prior authorization request forms must be submitted to:

EDS
Attn: Prior Authorization Unit - Suite 88
6406 Bridge Road
Madison, WI 53784-0088

The PA/RF, PA/HHTA, PA/DMEA, Home Care Assessment, Home Care Update, and amendment forms can be obtained by writing to:

EDS
Attn: Claim Reorder Department
6406 Bridge Road
Madison, WI 53784-0003

Please specify the form requested and the number of forms desired. Reorder forms are included in the mailing of each request for forms. Do not request forms by telephone.

D. PROCEDURES FOR OBTAINING PRIOR AUTHORIZATION (continued)

The HCFA-485, HCFA-486, and HCFA-487 forms are not available from EDS. When you complete these forms to provide information to Medicare for a client who is eligible for both Medicare and Medical Assistance, you may submit a copy of the completed forms to the WMAP, subject to the adjustments listed in Appendix 5 of this handbook. When you use these forms for non-Medicare clients, you may:

- use forms obtained from the Medicare intermediary and declare them on your Medicare cost report;
- copy or print your own supply of the forms; or
- purchase the forms from a supplier of federal forms.

Effective Date of Prior Authorizations
Under normal circumstances, to receive WMAP reimbursement for services requiring prior authorization, prior authorization must be obtained before the services are provided. However, in the case of provider or recipient retroactive eligibility, or the provision of a service requiring prior authorization which was performed in an extraordinary circumstance, retroactive prior authorization may be obtained. Extraordinary circumstances may include discharge from an institution or transfer from another agency.

Grant Date
In general, the grant date is the date EDS first received the request., since these services commonly must start before prior authorization approval is received. If a prior authorization request is returned for additional information, the request is backdated to the date the request

was first received by EDS.

When an earlier prior authorization request was denied and a new prior authorization request is submitted with information to justify approval, the request is backdated to the first EDS receipt date of the original denied prior authorization request when the earlier grant date is requested and the denied request is referred to in writing.

Prior Authorization Backdating
The WMAP will backdate a new prior authorization request if the following criteria are met:

1. Backdating is specifically requested in writing on the prior authorization request;

2. The request includes clinical justification for beginning services without prior authorization; and

3. One of the following criteria is also met:

    a. The request is received by EDS within 14 calendar days of the start of the provision of services;

    b. A court order or hearing decision requiring WMAP coverage is attached; or

D. PROCEDURES FOR OBTAINING PRIOR AUTHORIZATION (continued)

c. The recipient is retroactively eligible. (Indicate in element 18, "Description of Service", on the PA/RF, that the service was provided during a period of retroactive recipient eligibility. Show the actual date the service was provided.)

Refer to Section VIII of Part A of the WMAP Provider handbook for additional information on backdating or retroactive prior authorization.

E. RESPONSE TO PRIOR AUTHORIZATION REQUEST SUBMISSION

When is a Prior Authorization Request Approved as Requested?
A prior authorization is approved as requested if:

- the approved box is checked;
- the grant and expiration dates are indicated;
- a dated signature is indicated on the returned carbon copy; and
- a specific quantity is indicated on the returned copy.

Prior authorization requests are approved for the frequency and duration of the services. Frequency is the number of units (hours or visits) per day times the number of days per week. Duration is the number of weeks from the prior authorization grant date through the expiration date.

Providers may not utilize prior authorized services more quickly than the frequency approved. All services must be medically necessary. The WMAP will refer suspected cases of fraud or abuse for investigation.

When is a Prior Authorization Request Modified?
A prior authorization is modified if:

- the modified box is checked with an explanation;
- the grant and expiration dates are indicated;
- a dated signature is indicated on the returned carbon copy;
- a specific quantity is indicated on the returned carbon copy;
- the recipient is also notified by the fiscal agent of the right to a Fair Hearing Appeal; and
- refer to Part A of the WMAP Provider Handbook for further clarification on appeal procedures.

When is a Prior Authorization Request Denied?
A prior authorization is denied if:

- the denied box is checked with an explanation;
- a dated signature is on the returned carbon copy;
- both the recipient and the provider are notified;

E. RESPONSE TO PRIOR AUTHORIZATION

- the recipient is also notified by the fiscal agent of the right to a Fair Hearing Appeal; and
- refer to Part A of the WMAP Provider Handbook for further clarification on appeal

REQUEST SUBMISSION (continued)

procedures.

When is a Prior Authorization Request Returned?
A prior authorization is returned if:

- the return box is checked with an explanation OR a half sheet is attached with the appropriate return message indicated;
- a returned prior authorization is not denied;
- it is returned because additional information is needed; or
- the information on the prior authorization must be corrected.

F. PRIOR AUTHORIZATION FOR HEALTHCHECK "OTHER SERVICES"

Medically necessary services which are not otherwise covered may be covered if they are provided to a recipient under age 21 pursuant to a HealthCheck examination. Refer to Section II of this handbook for further information on HealthCheck "Other Services". All such services require prior authorization.

To request prior authorization, submit a PA/RF and the POC (HCFA-485) which describes the service to be provided and the medical necessity of the service. Indicate on the PA/RF that the request is for HealthCheck "Other Services". If the service is approved, the WMAP will assign a procedure code for the service. Always include a copy of the HealthCheck referral form indicating a referral for the services.

(Refer to Appendix 32 of Part A of the WMAP Provider Handbook for a sample HealthCheck referral form.) The referral must have been made within the past six months. Additional information documenting the individual's need for the service and the appropriateness of the service being delivered may be requested from the provider.

A. COORDINATION OF BENEFITS

The Wisconsin Medical Assistance Program (WMAP) is the payer of last resort for any service covered by the WMAP. If the recipient is covered under other health insurance, the WMAP reimburses that portion of the allowable cost remaining after all other health insurance sources have been exhausted. Refer to Section IX of Part A of the WMAP Provider Handbook for more detailed information on services requiring other health insurance, exceptions, and the "Other Insurance Discrepancy Report."

B. MEDICARE/ MEDICAL ASSISTANCE DUAL ENTITLEMENT

Recipients covered under both Medicare and Medical Assistance are referred to as dual-entitlees. Claims for Medicare covered services provided to dual-entitlees must be billed to Medicare and a final determination received from Medicare prior to billing Medical Assistance. In most instances Medicare and Medical Assistance coverage of home health services are consistent. Since Medicare Part A payment is payment in full, there will be no claim to Medical Assistance. However, any insurance amounts for durable medical equipment may be crossed over to the WMAP.

Claims denied by Medicare for provider billing error may not be billed to the WMAP. Providers must maintain records of the Medicare billing efforts for each recipient which establish that only medically necessary, Medicare noncovered services are billed to the WMAP.

Before billing the WMAP for services provided to a recipient confined to the residence and receiving skilled services, Medicare must be billed at least:

- at the beginning of each episode of care;
- after each hospitalization; and
- after each deterioration or change in condition which requires an increase in the amount, type, or level of care.

Episode of care may be interpreted as a period of time that commences with the start date and ends with the discharge date. This may be a "demand bill" or a bill for payment, as appropriate. If Medicare denies the claim because the recipient is receiving maintenance services, the WMAP may be billed using the Medicare status code M-7 (Medicare-Denied). Maintenance services would be any services which are medically necessary and required on a regular basis to maintain the recipient's health, but have no finite and predictable end date.

For nursing or nursing and aide services in excess of 35 hours per week, the first eight hours per day, 35 hours per week, must be billed to Medicare and only the balance may be billed to the WMAP. When home health aide services are reimbursable by Medicare, personal care services may only be billed to the WMAP for those hours in excess of Medicare's home health aide benefit of eight hours per day, 35 hours per week. When billing, use the Medicare status code M-1 (Medicare Benefits Exhausted).

Covered Medical Assistance services which are not consistent with Medicare's coverage limits under part-time intermittent home health care (i.e., home health aide or personal care worker services without skilled care intervention or services to recipients who are not confined to home) may be billed to the WMAP without first billing Medicare. When billing, use the Medicare status code M-8 (Non-Covered Service).

Refer to Appendix 22 of this handbook for information on how to bill Medical Assistance for dual-entitlees.

C. MEDICARE QMB-ONLY

Qualified Medicare Beneficiary Only (QMB-only) recipients are only eligible for WMAP payment of the coinsurance and the deductibles for Medicare-covered services. Since Medicare covers home health services, crossover claims for the deductible and any copayment amounts for Medicare

allowed charges will be reimbursed for QMB-only recipients.

D. BILLED AMOUNTS

Providers must bill the WMAP their usual and customary charge for services provided, that charge being the amount charged by the provider for the same service when provided to private pay patients. For providers using a sliding fee scale for specific services, usual and customary means the median of the individual provider's charge for the service when provided to non-Medical Assistance patients. Providers may not discriminate against Medical Assistance recipients by charging a higher fee for the service than is charged to a private pay patient.

E. BILLING INCREMENTS

Home health aide initial visits, home health aide subsequent visits, home health nursing initial visits, home health nursing subsequent visits and therapy visits are reimbursed according to a maximum allowable fee per visit. Providers must bill each home health visit as one unit of service per day. If the quantity billed is not an increment of a whole unit, the service is denied.

Private duty nursing services are reimbursed based on an hourly maximum allowable fee. Providers must bill in even hour or half-hour increments, rounded to the nearest half hour. If the quantity billed is not an increment of .5 or .0, the service is denied. Refer to Appendix 16 of this handbook for rounding guidelines to be used when submitting claims.

F. BILLING PRIOR AUTHORIZED SERVICES WITH NON-PRIOR AUTHORIZED SERVICES

Prior authorized services may be billed on the same claim form as non-prior authorized services subject to the following limitations:

- Services prior authorized under separate prior authorization numbers must be billed on separate claim forms.
- When billing a particular service, such as the initial RN visit, which is provided prior to the effective date of the prior authorization, dates of service which have prior authorization and dates of service which do not have prior authorization must be billed on separate claim forms. Otherwise, dates of service not having prior authorization would deny due to not being within the grant and expiration date of the prior authorization number on the claim form.

G. CLAIM SUBMISSION

Billing for Home Health Services, Private Duty Nursing Services, and Durable Medical Equipment (DME)

A copy of the WMAP DME Index may be obtained by writing to the EDS Correspondence Unit at the address listed in Appendix 2 of Part A of the WMAP Provider Handbook. The DMS maximum allowable fee schedule may be purchased by writing to the address listed in Appendix 3 of Part A of the WMAP Provider Handbook.

Home health services and DME items must be submitted using the UB-92 claim form. A sample claim form can be found in Appendix 17 of this handbook. Home health services and private duty nursing services, and DME submitted on any other paper form than the UB-92 claim form are denied.

G. CLAIM SUBMISSION (continued)

The UB-92 claim form must be completed according to instructions included in Appendix 17 of this handbook. When series billing, a maximum of four dates of service may be entered on 1 item (detail), provided that:

1. All dates of service are in the same calendar month;
2. Procedure codes are the same for all four dates of service;

3. The charges for the procedures are identical;
4. The quantity of units is the same for all dates of service.

The quantity entered for each detail line represents the number of units for each day, multiplied by the number of days of service. Similarly, the charges for each detail line represent the charges for that service multiplied by the number of days of service. If two or more detail lines must be used for the same procedure code (i.e., when billing is more than four identical dates of service in a calendar month), the additional dates of service that can be billed to the same procedure code must be indicated on a separate detail line, along with the appropriate units and charges for those dates of service. Each detail line must always include the correct units and charges for the dates on that line or the claim will be denied. Refer to Appendix 17b of this handbook for an example of series billing.

A Home Health UB-92 Billing Manual can be obtained by writing to:

Wisconsin Hospital Association
5721 Odana Road
Madison, WI 53719

When ordering the manual, please specify that the order is for the Home Health UB-92 Manual.

The UB-92 claim form is not provided by the WMAP or EDS. It may be obtained from a number of forms suppliers. One such source is:

Standard Register
Post Office Box 6248
Madison, WI 53716
Telephone: (608) 222-4131

Billing for Disposable Medical Supplies (DMS)

General Information

Disposable medical supplies (DMS) and enteral nutrition products and supplies provided by home health agencies must be billed on the WMAP drug claim form. Claims received by EDS for these services on any claim form other than the drug claim form are denied.

Refer to Appendices 18 and 19 of this handbook for a sample drug claim form and claim form completion instructions.

Drug claim forms are available from:

EDS
Attn: Claim Reorder
6406 Bridge Road
Madison, WI 53784-0003

G. CLAIM SUBMISSION (continued)

Completed claims submitted for payment must be mailed to the following address:

EDS
6406 Bridge Road
Madison, WI 53784-0002

Claim Submission Limitation

All products and supplies dispensed to the same recipient, by the same provider, during the same calendar week (Sunday through Saturday), must be billed on the same claim. The policy applies to

any combination of products or services billed on the drug claim form (paper or paperless), including legend drugs, over-the-counter (OTC) drugs, disposable medical supplies (DMS), and nutritional supplies. This policy does not apply to services that are billed on other claim forms, such as the HCFA 1500 or UB-92.

> ***Important Note:*** The WMAP encourages providers to bill products dispensed in different weeks on the same claim whenever possible. However, products dispensed in the same week may no longer be billed on different claims, except in the instances noted below.

Once a claim is paid by the WMAP, subsequent drug claims are denied if they are for products dispensed to the same recipient, by the same provider, for the same week as a previously paid claim. The Explanation of Benefits message on the Remittance and Status Report will identify the paid claim.

The provider must submit an Adjustment Request Form to EDS for reimbursement of services not billed on the original claim, or for reimbursement of denied details on a partially paid claim. With partially paid claims, providers may not simply find the billing error, correct it, and resubmit the claim with the paid details crossed out.

Claims which are totally denied must be corrected and resubmitted for reimbursement. An Adjustment Request Form which is submitted for a totally denied claim is denied. Refer to Appendices 27 and 27a of Part A of the WMAP Provider Handbook for information on submitting an Adjustment Request Form.

Exemptions to the Claim Submission Limit

The only exemptions to the policy limiting the number of claim submissions are:

- If the supplies have been prior authorized with two or more prior authorization numbers, then two or more electronic or paper claims may be submitted for a calendar week.
- Paper claims with the variance check indicator "V-Y" ("Verified-Yes") in element 2 of the drug claim form, which are submitted when the quantity and charge amount of a denied detail are correct, are exempt from the claim submission limit.
- Paper claims for compounded drugs are exempt from the claims submission limit.

Allowable Situations for a Second Claim Submission

In addition, the WMAP allows a second claim in a calendar week (Sunday through Saturday) in the following situations:

G. CLAIM SUBMISSION (continued)

- If more than six products are dispensed during a calendar week and the provider submits paper claims, then two or more paper claims may be submitted for a calendar week. (This is because there are only six detail lines on a paper claim.) However, if multiple paper claims are submitted during the same calendar week, each claim must have all six details completed except for the last claim submitted.
- If more than 25 products are dispensed during a calendar week and the provider submits electronic claims, then two or more electronic claims may be submitted for a calendar week. (This is because there are only 25 details lines on an electronic claim.) However, if multiple electronic claims are submitted during the same calendar week, each claim must have all 25 details completed except for the last claim submitted.

- If a provider or vendor's weekly billing cycle is different than Sunday through Saturday, and additional supplies are dispensed to the same recipient after the end of the provider's billing period, a second claim may be submitted for the additional products.

- If a monthly biller needs to bill a second time because a month ends on any day other than Saturday, then a second claim may be submitted for services provided after the end of the provider's billing period.

- If one or more details on a claim need to be submitted for other insurance payment prior to submitting to the WMAP, a provider may submit one claim to the WMAP for the services which are not covered by other insurance, and a second claim may be submitted for the calendar week after the other insurance has processed the claim.

A provider may define their own billing period, as long as the billing period is greater than or equal to one week. When defining their own billing period, a provider must submit no more than one claim per week, per recipient, except for the situations listed above.

If a provider submits a claim that qualifies for submission of a second claim in a calendar week, only one claim may be submitted per calendar week in addition to the original claim. Additional details can only be reimbursed by adjusting a previously paid claim.

If a provider submits a claim that qualifies for an exemption, the provider may submit as many claims per calendar week as the number of exemptions. However, providers are encouraged to combine details on claims, to the extent possible, in order to minimize the number of claims submitted.

Refer to Appendix 24 of this handbook for examples of how providers are to submit claims in a variety of situations.

Paperless Claim Submission

As an alternative to submission of paper claims, EDS is able to process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted electronically have the same legal requirements as claims submitted on paper and are subjected to the same processing requirements as paper claims. Providers submitting electronically can usually reduce their claim submission errors. Additional information on paperless claim submission is available by contacting the Electronic Media Claims (EMC) Department at:

G. CLAIM SUBMISSION
(continued)

EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

Sample electronic screens can be found in Appendices 17 and 19 of this handbook. A paperless claims request form is located in Appendix 21 of this handbook.

Submission of Claims

All claims for services rendered to eligible WMAP recipients must be received by EDS within 365 days from the date such service was rendered. This policy pertains to all claim submissions, resubmissions, and adjustment requests.

Exceptions to the claim submission deadline and requirements for submission to Late Billing Appeals can be found in Section IX-F of Part A of the WMAP Provider Handbook.

H. DIAGNOSIS CODES

All diagnoses must be from the International Classification of Diseases, 9th Edition, Clinical Modifications (ICD-9-CM) coding structure.

Claims received without the appropriate ICD-9-CM code are denied.

The complete ICD-9-CM code book can be ordered by writing to the address listed in Appendix 3 of Part A of the WMAP Provider Handbook.

Providers should note the following diagnosis code restrictions:

- Codes with an "E" prefix must not be used as the primary or sole diagnosis on a claim submitted to the WMAP.
- Codes with an "M" prefix are not acceptable on a claim submitted to the WMAP.

I. PROCEDURE CODES

All claims submitted to the WMAP must include both service descriptions and procedure codes. HCFA Common Procedure Coding System (HCPCS) codes are required on all home health care claims. Claims or adjustments received without HCPCS codes are denied. Allowable HCPCS codes and their descriptions for home health services are listed in Appendix 1 of this handbook.

All DMS must be submitted using the appropriate National Drug Code (NDC).

J. FOLLOW-UP TO CLAIM SUBMISSION

It is the responsibility of the provider to initiate follow-up procedures on claims submitted to EDS. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Providers are advised that EDS will take no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to EDS. Section X of Part A of the WMAP Provider Handbook includes detailed information regarding:

- the Remittance and Status Report
- adjustments to paid claims
- return of overpayments
- duplicate payments
- denied claims
- Good Faith claims filing procedures